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IN THE

Supreme Court of the United States

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

Petitioner,

—v.—

FRANK REGULA,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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155 pgs

QUESTIONS PRESENTED

1. Whether the Ninth Circuit erred in holding that a private disability plan subject to the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 ("ERISA") must follow the Social Security Act's regulation giving controlling weight to the claimant's treating physician's opinion, a holding rejected by six other Circuits, and which conflicts with the deference accorded to benefit plan administrators under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112-13 (1989) and disrupts the uniform administration of benefit plans that is a primary goal of ERISA, *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001).

2. Whether the Ninth Circuit erred in holding that an ERISA plan which, as ERISA permits, is administered by employees of the employer and funded by an employer's irrevocable contributions to a trust established to pay benefits pursuant to the plan, suffers from a conflict of interest as a matter of law, a holding which is in conflict with the holdings of at least four other Circuits.

LIST OF PARTIES

The only parties are those listed in the caption of this case.

RULE 29.6 STATEMENT

Although Petitioner is not a corporation, it is a funded benefit plan sponsored by Delta Air Lines, Inc., which is a publicly-held corporation. *See* Sup. Ct. R. 29.6.

TABLE OF CONTENTS

	PAGE
QUESTIONS PRESENTED	i
LIST OF PARTIES	ii
RULE 29.6 STATEMENT	ii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
STATEMENT OF JURISDICTION	2
STATUTORY PROVISIONS INVOLVED	2
STATEMENT OF THE CASE	2
1. Legal Background Regarding ERISA Claims	3
2. The Plan And Regula's Claim For Benefits	5
3. Proceedings In The District Court And The Court Of Appeals	8
REASONS FOR GRANTING THE PETITION	12

PAGE

I. Certiorari Should Be Granted On The Question Presented Regarding The Application Of The Treating-Physician Rule To ERISA-Disability Benefits Cases Because It Is A Significant Error Which Has Divided The Circuits And Requires Correction By This Court 15

II. Certiorari Should Be Granted On The Conflict Of Interest Issue Because It Requires Different District Courts To Reach Conflicting Decisions Under The Same Plan..... 23

CONCLUSION..... 26

TABLE OF AUTHORITIES

Federal Cases PAGE

Abnathya v. Hoffmann-La Roche Inc., 2 F.3d 40 (3d Cir. 1993) 22, 25

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) 4, 18

Brown v. Retirement Comm. of Briggs & Stratton Retirement Plan, 797 F.2d 521 (9th Cir. 1986) 20

Buckley v. Metropolitan Life Ins., Inc., 115 F.3d 936 (11th Cir. 1997) (per curiam) 25

Connors v. Connecticut General Life Ins. Corp., 272 F.3d 127 (2d Cir. 2001) 22

Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73 (1975) 25

Delta Family-Care Disability & Survivorship Plan v. Marshall, 258 F.3d 834 (8th Cir. 2001) ..... *passim*

Donaho v. FMC Corp., 74 F.3d 894 (1996) 9, 20

Donato v. Metropolitan Life Ins. Co., 19 F.3d 375 (7th Cir. 1994) 22

Dowden v. Blue Cross & Blue Shield of Tex., Inc., 126 F.3d 641 (5th Cir. 1997) 11, 17, 20

Egelhoff v. Egelhoff, 532 U.S. 141 (2001) ..... *passim*

Elliott v. Sara Lee Corp., 190 F.3d 601 (4th Cir. 1999) 9

PAGE

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) ..... *passim*

Fletcher-Merrit v. NorAm Energy Corp., 250 F.3d 1174 (8th Cir. 2001) 11

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 4, 14

Gallo v. Amoco Corp., 102 F.3d 918 (7th Cir. 1996) 24, 25

Hale v. Trustees of United Mine Workers' Health & Retirement Funds, 23 F.3d 899 (4th Cir. 1994) 19

Hughes Aircraft Co. v. Jacobsen, 525 U.S. 432 (1999) 25

Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co., 520 U.S. 510 (1997) 4

Jackson v. Metropolitan Life, 2001 WL 1450811 (6th Cir. Oct. 29, 2001) 21

Jett v. Blue Cross and Blue Shield of Ala., Inc., 890 F.2d 1137 (11th Cir. 1989) 9, 21

Lockheed Corp. v. Spink, 517 U.S. 882 (1996) .. 24

Madden v. ITT LTD Plan for Salaried Employees, 914 F.2d 1279 (9th Cir. 1990) 19

Manion v. N.P.W. Med. Center of N.P. Pa., 676 F. Supp. 585 (M.D. Pa. 1987) 17

McKenzie v. General Tel. Co. of Ca., 41 F.3d 1310 (9th Cir. 1994) 11

PAGE

Mertens v. Hewitt Assoc's, 508 U.S. 248 (1993). 24

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 4

Morales v. Apfel, 225 F.3d 310 (3d Cir. 2000)... 3

Pagan v. NYNEX Pension Plan, 52 F.3d 438 (2d Cir. 1995) 19

Paramore v. Delta Air Lines, Inc., 129 F.3d 1446 (11th Cir. 1997)..... 19

Pegram v. Herdrich, 530 U.S. 211 (2000)..... 18

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987) 15

Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011 (5th Cir. 1992)..... 9

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) 3

Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co., 32 F.3d 120 (4th Cir. 1994).....9, 11, 20

Skredtvedt v. E.I. DuPont de Nemours, 268 F.3d 167 (3rd Cir. 2001) 22

Turner v. Delta Family-Care Disability and Survivorship Plan, ___ F.3d ___, 2002 WL 1040194 (11th Cir. Apr. 9, 2002) (per curiam) .....*passim*

Varity Corp. v. Howe, 516 U.S. 489 (1996)..... 4, 19

Wilczynski v. Kemper Nat'l Ins. Co., 178 F.3d 933 (7th Cir. 1999) 20

PAGE

Woolsey v. Marion Lab's, Inc., 934 F.2d 1452 (10th Cir. 1991) 25

Federal Statutes

28 U.S.C. § 1254(1) 2

Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 i

ERISA § 3(1)(A), 29 U.S.C. § 1002(1)(A) 3

ERISA § 201(1), 29 U.S.C. § 1051(1) 3

ERISA § 204(b)(1)(B)(iv), 29 U.S.C. § 1054(b)(1)(B)(iv) 4, 18

ERISA § 204(b)(1)(C), 29 U.S.C. § 1054(b)(1)(C) 4, 18

ERISA § 204(b)(1)(G), 29 U.S.C. § 1054(b)(1)(G) 4, 18

ERISA § 301(a)(1), 29 U.S.C. § 1081(a)(1) 3

ERISA § 404, 29 U.S.C. § 1104 15

ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) 24

ERISA § 406(b), 29 U.S.C. § 1106(b) 24

ERISA § 409(a), 29 U.S.C. § 1109(a) 24

ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) 4, 5

ERISA § 4021(a)(1), 29 U.S.C. § 1321(a)(1) 3

42 U.S.C. §§ 401-33 5

PAGE

Federal Regulations

20 C.F.R. §§ 404.1-.2127, 416.101-.2227 5

20 C.F.R. § 404.1527(d)(2) 2

29 C.F.R. § 2560.503-1 ..... 4, 17

Court Rules

Sup. Ct. R. 29.6 ii

Other Materials

www.bls.gov/news.release/ebs2.t02.htm 13

www.freeerisa.com/5500/InstantView.asp?mainID =298336 13

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ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

Delta Family-Care Disability and Survivorship Plan respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App. *infra*, 1a-46a) is reported at 266 F.3d 1130. The opinion of the district court (App. *infra*, 47a-63a) is unreported.

STATEMENT OF JURISDICTION

The judgment of the court of appeals was entered on September 24, 2001. An order denying a timely petition for rehearing *en banc* was entered on March 15, 2002. (App. *infra*, 67a-68a). This Petition for a Writ of Certiorari is filed within 90 days of that date. The Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant provisions of the Employee Retirement Income Security Act of 1974, a regulation thereunder, and a regulation of the Social Security Act are reproduced in the Appendix, *infra*, 69a-99a.

STATEMENT OF THE CASE

Frank Regula ("Regula") brought this action against the Delta Family-Care Disability and Survivorship Plan (the "Plan") in the United States District Court for the Central District of California seeking reinstatement of his long-term disability benefits under the Plan. The district court entered judgment in favor of the Plan. On the issues relevant to this petition, the district court held that the Social Security Act's treating-physician rule[1]

[1] The "treating-physician rule" is the commonly used term for a strong presumption that the opinion of the claimant's physician is to be followed in deciding whether a claimant is entitled to benefits. Because it actually only refers to the claimant's physician even when other physicians have examined claimant, it is more accurately called the "claimant's physician's rule." It is codified in Social Security Act regulations as a rule which gives the claimant's physician's opinion "controlling weight" if it is supported by accepted medical techniques and not inconsistent with other substantial evidence of record. 20 C.F.R. § 404.1527(d)(2). The Third Circuit has stated in Social Security Act cases that the claimant's physician's opinion is usually to be

had no application to ERISA-disability benefits cases and that the Plan's decision was not an abuse of discretion. Applying the treating-physician rule would improperly limit the discretion accorded to the Plan under controlling Supreme Court law. (Regula had not argued that the Plan operated under a conflict of interest).

The court of appeals, in a 2-to-1 decision, reversed. It held that the treating-physician rule should be applied to ERISA-disability benefit claims. It also held *sua sponte* that the traditional abuse of discretion standard of review did not apply because the Plan suffered from a *per se* conflict of interest. The court of appeals ordered that if the Plan could not rebut the presumption that the Plan's decision was the result of a conflict of interest, the *de novo* standard of review should apply.

1. Legal Background Regarding ERISA Claims.

ERISA-welfare benefit plan sponsors are generally permitted to decide what types of welfare benefits they will offer and on what terms those benefits will be provided. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).[2] Disability benefits plans, like all welfare benefit plans, are exempt from ERISA's participation, vesting, funding and plan termination insurance obligations applicable to employee pension benefit plans. *See* 29 U.S.C. §§ 1051(1), 1081(a)(1) and 1321(a)(1). "ERISA

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given great weight. *See Morales v. Apfel*, 225 F.3d 310, 317 (3d Cir. 2000). The Ninth Circuit has phrased the rule somewhat differently in this case, stating that a Plan must have "specific, legitimate" reasons for rejecting a claimant's physician's opinion based on other evidence in the record. (App. *infra*, 16a-17a.) While the court of appeals avoided using the specific terms "controlling weight" or "great weight," the effect of the court of appeals' holding in this case is to afford such weight to the opinion of claimant's physician. *See infra*, p. 16.

[2] ERISA defines the term "employee welfare benefit plan" to include disability benefits plans. *See* 29 U.S.C. § 1002(1)(A).

itself 'does not regulate the substantive content of welfare-benefit plans.' " *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985)).

In drafting ERISA, one of Congress's chief concerns was "not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). This concern was addressed by one of ERISA's goals, "which was to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.' " *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)). "Uniformity is impossible, however, if plans are subject to different legal obligations in different states." *Id.*

With respect to welfare benefit claims, by regulation ERISA imposes a mechanism for benefit claimants to administratively appeal adverse benefits decisions, which includes the right of the benefit claimant to submit information in support of a claim and to know the basis of the plan administrator's decision. *See* 29 C.F.R. § 2560.503-1. By statute, ERISA provides a mechanism for the enforcement of the terms of the Plan. *See, e.g.*, 29 U.S.C. § 1132(a)(1)(B). Further, when drafting ERISA, Congress specifically referred to the Social Security Act when it wanted to, *see* 29 U.S.C. §§ 1054(b)(1)(B)(iv), 1054(b)(1)(C), 1054(b)(1)(G); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 514-15 (1981) (same), but none of ERISA's provisions or regulations authorize the application of the Social Security Act's treating-physician rule.

In an action by a participant under 29 U.S.C. § 1132(a)(1)(B), the Plan's decision is subject to judicial review under either the arbitrary or capricious[3] or *de novo* standards, depending on the language of the Plan. *See Firestone Tire Co. v. Bruch*, 489 U.S. 101, 112-13 (1989). In *Firestone* this Court held that when a plan's terms vest discretion in the plan administrator to make benefits determinations, the determination will only be disturbed if it is arbitrary or capricious. *Id.* at 110-15. The level of deference given under that standard may be diminished by a demonstrated conflict of interest, but under *Firestone* a conflict of interest does not reduce the standard of review from arbitrary or capricious to *de novo*. *See id.* at 115.

Congress's approach in establishing a *public* welfare benefit plan was much different. Within the Social Security Act, Congress has established an elaborate, highly regulated public disability benefit authority. *See, e.g.*, 42 U.S.C. §§ 401-33; 20 C.F.R. §§ 404.1-.2127, 416.101-.2227. Although the review of Administrative Law Judge decisions under the Social Security Act is also by its terms somewhat deferential, that deference is within the much stricter confines of the Social Security Act's all encompassing regulatory scheme.

2. The Plan And Regula's Claim For Benefits.

This case involves an action by Regula for the reinstatement of his long-term disability benefits under the Plan. The Plan is a non-contributory, employee welfare benefit plan subject to ERISA. (App. *infra*, 101a-03a.) It provides, *inter alia*, long-term disability benefits to non-pilot employees of Delta Air Lines, Inc. (App. *infra*, 100a-01a.) It is funded by non-reversionary contribu-

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[3] The alternate term, "abuse of discretion," is used by some courts as being synonymous with "arbitrary or capricious."

tions to a benefits trust which pays benefits as approved by the Plan's administrator. (App. *infra*, 102a-03a.) The Plan's administrator is the Administrative Committee of Delta Air Lines, Inc., which is comprised of Delta employees. (App. *infra*, 103a-04a.)

To receive long-term disability benefits under the Plan, a claimant must be unable to "continuously and totally engage in any occupation whatsoever for compensation or profit, including part-time work." (App. *infra*, 100a.) The claimant must also remain under the care of a physician for his disabling condition. (App. *infra*, 100a.) The Plan requires the claimant to provide updated medical information at regular intervals. (App. *infra*, 4a, 49a & 100a-01a.) It is undisputed that the Plan's language gives the Plan's administrator sufficient discretion so that its decisions are reviewed under the abuse of discretion standard. (App. *infra*, 25a.)

In 1987, the Plan approved Regula's claim for long-term disability benefits. (App. *infra*, 4a.) Plaintiff claimed he was disabled due to an injured hand, back and neck and that he was psychiatrically disabled due to depression. (App. *infra*, 106a-09a.) The continued receipt of these benefits was expressly conditioned upon, among other items, Regula's provision of confirming medical evidence at regular intervals. (App. *infra*, 4a.)

In a report dated August 8, 1994, Regula's psychologist, Sandra Smith, Ph.D., stated that Regula might be able to engage in part-time work in six to twelve months with appropriate vocational rehabilitative services. (App. *infra*, 50a.) As of 1994, however, Regula's alleged orthopaedic injuries were no longer supported by an orthopaedist. (App. *infra*, 107a-08a.) Regula's Chiropractor, Dean H. Cummings, D.C., was the only individual who then stated Regula was disabled physically. (App. *infra*, 108a.)

At the Plan's request, Regula was then examined by Dr. Rajeshwari Kumar, an independent orthopaedic and vocational rehabilitative specialist. (App. *infra*, 6a & 50a.) Dr. Kumar examined Regula and detailed her findings in an 8-page report. (App. *infra*, 42a & 50a.) She concluded that Regula "is definitely [physically] capable of gainful employment performing some type of work." (App. *infra*, 42a.) After receiving Dr. Kumar's report, Dr. Smith, a psychologist, criticized Dr. Kumar's *orthopaedic* conclusions and separately reversed course, stating that Regula's psychological condition prevented him from working. (App. *infra*, 51a.)

After receiving Dr. Smith's criticism of Dr. Kumar's orthopaedic report and Dr. Smith's revised opinion regarding Regula's psychological ability to work, the Plan arranged for Regula to be examined by an independent psychiatrist, Dr. James O'Brien. (App. *infra*, 51a.) He concluded that Regula was "consciously exaggerating his psychological and orthopaedic difficulties." (App. *infra*, 6a.) Regula's resistance to any type of psychological treatment that would lead to symptomatic relief was also unjustified in Dr. O'Brien's opinion. (App. *infra*, 108a.) He concluded that "Mr. Regula can return to work immediately and that there is no type of work within his job description that he would not be able to do." (App. *infra*, 51a.)

The Administrative Committee was persuaded by Drs. Kumar and O'Brien's reports. (App. *infra*, 106a-09a.) It was also disturbed by Dr. Smith's criticism of the opinion of a professional outside of her area of practice and her failure to prescribe any medical therapy for Regula even though she posited that he was disabled. (App. *infra*, 107a-08a.) The Administrative Committee considered and rejected Regula's argument that the treating-physician rule applies to ERISA disability cases. (App.

infra, 108a-09a.) Even if the rule did apply, the Committee specifically explained that it credited Dr. Kumar's opinion more than Dr. Cummings' because Dr. Kumar was an examining orthopaedic specialist and Dr. Cummings was a chiropractor. Further, it credited Dr. O'Brien's opinion over that of Dr. Smith because of his specific reasons why he concluded that Regula was malingering. (App. *infra*, 109a.)

3. Proceedings In The District Court And The Court Of Appeals.

On October 17, 1996, Regula sued the Plan claiming that the termination of his long-term disability benefits was an abuse of discretion and violated ERISA. (App. *infra*, 51a.) The district court upheld the Plan's decision because the current medical evidence before the Administrative Committee demonstrated that Regula was not disabled as the Plan defines that term. (App. *infra*, 57a-59a & 65a.) (Regula did not contend that a conflict of interest affected the Plan's decision. App. *infra*, 47a-62a.) The district court rejected Regula's claim that the Plan must give greater weight to his chosen physician's opinion because that rule would materially diminish the discretion afforded to the Plan. (App. *infra*, 55a-57a.)[4]

A divided Panel of the Ninth Circuit reversed. (App. *infra*, la-46a.) First, the court of appeals held that the treating-physician rule, previously a product of only Social Security Act regulation and decisions, also applied to ERISA disability benefit claims. (App. *infra*, 15a-24a.) The court of appeals held that the rule would apply when an opinion of an independent physician contradicts the opinion of the claimant's physician and is not based on independent clinical findings, or rests on

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[4] The district court also rejected Regula's other arguments which are not relevant to this petition. (App. *infra*, 59a-62a.)

clinical findings also considered by the treating physician. (App. *infra*, 16a-17a.) In that event, the Plan's administrator can only reject the opinion of the treating physician only if it gives "specific, legitimate" reasons based on substantial evidence in the record. (App. *infra*, 17a.)

The court of appeals believed that the other Circuits were split on this issue. It characterized the Fourth Circuit as expressing in *dicta* doubts about the treating-physician rule's applicability in the ERISA disability-benefit claim context. (App. *infra*, 16a n.5.)[5] The court of appeals cited the Eighth Circuit as applying the rule, *though it noted that a more recent precedent, involving the very same benefit plan at issue in this case, apparently reached the opposite conclusion.* (App. *infra*, 16a n.5.)[6] The court of appeals noted that the Fourth, Fifth and Eleventh Circuit had rejected the rule in cases involving health benefits determinations as opposed to disability benefits terminations. (App. *infra*, 22a.)[7] The

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[5] *Id.* (citing *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999)).

[6] *Id.* (citing *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996) and citing to *Delta Family-Care Disability & Survivorship Plan v. Marshall*, 258 F.3d 834, 842-43 (8th Cir. 2001) with the citation signal "*but see*").

[7] *Id.* (citing *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992); *Jett v. Blue Cross and Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989)). Since the Ninth Circuit's decision in this case, the Eleventh Circuit has held that the Ninth Circuit incorrectly read the Eleventh Circuit's rejection of the treating-physician rule too narrowly. In *Turner v. Delta Family-Care Disability and Survivorship Plan*, ___ F.3d ___, 2002 WL 1040194 *3-4 (App. *infra*, 116a) (11th Cir. Apr. 9, 2001), a case under this very Plan, the Eleventh Circuit rejected the application of the treating-physician rule to disability benefits claims.

Ninth Circuit distinguished these cases because it assumed that, unlike health insurance benefits payments, disability benefits are paid to the employee as opposed to the treating physician. (App. *infra*, 23a).

Second, the Ninth Circuit held *sua sponte* that the Plan's administrator, the Administrative Committee, operated under a *per se* conflict of interest. (App. *infra*, 26a.) It held that since the Plan was funded by Delta Air Lines, Inc. and decisions regarding the Plan were made by a committee composed of Delta employees, a *per se* conflict existed. (App. *infra*, 26a.) Then, citing the Administrative Committee's failure to apply the newly-minted treating-physician rule, it ruled that the conflict appeared to affect the Plan's actions. (App. *infra*, 30a.) The court of appeals ordered the district court to consider whether the Plan could rebut the presumption that the *per se* conflict affected the Administrative Committee's decision. (App. *infra*, 31a.) If the district court were to find that the conflict did affect the Administrative Committee's decision, then the court of appeals held that the district court must apply the *de novo* standard of review. (App. *infra*, 27a.)

Senior Circuit Judge Brunetti dissented. (App. *infra*, 31a-46a.) Because Judge Brunetti concluded that Regula waived any argument regarding a conflict of interest, he did not further address that issue. (App. *infra*, 32a.) Next, he concluded that the treating-physician rule should not apply to ERISA benefit claims. (App. *infra*, 37a-41a.) He noted that a Social Security regulation was an inapt analogy to ERISA. The Administrative Law Judge's disability determinations in the Social Security context are strictly confined by a complex regulatory scheme, while ERISA gives plans great discretion in determining whether to award benefits. (App. *infra*, 36a-37a.) For this reason Judge Brunetti stated that the court of appeals'

decision was inconsistent with the discretion accorded to the Plan under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S., 101, 115 (1989). (App. *infra*, 37a.) He stated that his conclusion was consistent with Ninth Circuit precedent which rejected the importation of the Social Security Act's vocational evidence requirement to ERISA cases. (App. *infra*, 38a.)[8] According to Judge Brunetti *all* of the courts of appeals faced with the same issue disagreed with the Ninth Circuit in this case. (App. *infra*, 39a.)[9] Although Judge Brunetti noted that the Eighth Circuit's opinion in *Donaho* could be read to support the majority's application of the treating-physician rule, he noted that two cases, decided within the months prior to the court of appeals' decision in this case, minimized whatever precedential effect *Donaho* had. (App. *infra*, 40a.)[10]

Judge Brunetti also rejected the majority's distinction of cases applying the rule in the health-benefits claims context. "Because ERISA plans ordinarily requires a claimant to reprove their disability periodically," the physician opining disability in this case "almost guarantees another visit by that claimant" each time that he or she stated that the claimant was still disabled. (App. *infra*, 40a.) Finally, he noted that the Plan properly relied on the detailed reports of Drs. Kumar and O'Brien and held that the Plan also properly considered Dr. Smith's opinions to be less probative and potentially

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[8] *Id.* (citing *McKenzie v. General Tel. Co. of Ca.*, 41 F.3d 1310, 1317 (9th Cir. 1994)).

[9] *Id.* (citing *Dowden v. Blue Cross & Blue Shield of Texas, Inc.*, 126 F.3d 641, 644 (5th Cir. 1997); *Sheppard*, 32 F.3d at 126 (4th Cir.); *Jett*, 890 F.2d at 1139-40 (11th Cir.)).

[10] *Id.* (citing *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 (8th Cir. 2001); *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 n.3 (8th Cir. 2001)).

biased based on her statements about Dr. Kumar and her abrupt change in opinion. (App. *infra*, 41a-43a.)

The Plan filed a petition for rehearing *en banc* that raised both of the questions presented in this Petition. On March 15, 2002, the court of appeals denied the petition. (App. *infra*, 67a-68a.)[11]

REASONS FOR GRANTING THE PETITION

The court of appeals' ruling improperly limits the discretion this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) accords to this and thousands of other welfare benefit plans with respect to both issues presented in the Petition. Just as importantly, the court of appeals' ruling disrupts a uniformity in federal benefits law that Congress sought in enacting ERISA by creating a conflict in the Circuits.

First, by applying the treating-physician rule to ERISA cases the court of appeals' decision mistakenly wrenches a single regulation from the Social Security Act's complex decision-making scheme and applies it to ERISA plans regulated by a simpler and less restrictive set of laws. The court of appeals' reasoning is even more problematic than its holding since it would be equally applicable to the importation of many other aspects of Social Security law to ERISA. The Ninth Circuit's reasoning is particularly harmful because it will lead to even greater commingling of the private and public benefits systems that Congress intended to keep separate.

The effect of applying this rule to future ERISA cases will be to give "controlling" or "great" weight to

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[11] The Order denying the petition specified that Judge Brunetti recommended granting rehearing *en banc* and that an active judge had requested a vote to rehear the case *en banc*, but did not state how many judges voted in favor of rehearing *en banc*. *Id.*

the claimant's physician in many cases. As a result, plans will face greater uncertainty in deciding claims since their discretion is cabined by this Social Security Act rule. In the long-term, this will require the application of different rules to beneficiaries under the same plan, a result which will necessarily increase the costs of administering such a plan. Costs will also be increased either by either awarding benefits in borderline cases where they should not be awarded or by increasing the litigation of these cases decided by the plan. The likely, but unfortunate consequence of this increase in costs will inevitably be the reduction of at least the amount of benefits, if not the type of benefits, available to employees. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (consequences of additional administrative burdens on ERISA plans will ultimately harm beneficiaries).

The aggregate amount of plan participants and the dollar amount of benefits at issue is staggering. This is a benefit which over 50% of the employees of medium and large-size companies (*i.e.*, 100 or more employees) in America elect. *See* Bureau of Labor Statistics, National Compensation Survey for 1999, *www.bls.gov/news.release/ebs2.t02.htm*. Further, in the most recent year reported, this Plan alone had over 71,000 participants and paid over $32 million ($32,000,000.00) in benefits directly to participants. *See www.freeerisa.com/5500/InstantView.asp?MainID=298336* (refer to lines 7(d) and 32(e)(1)). Given that the benefits provided by the Plan are not unique to Delta Air Lines, Inc., the plan sponsor in this case, similar amounts can be expected to be paid under similar circumstances by other large corporations.

Second, the court of appeals' decision is also contrary to the decisions of the Eighth and Eleventh Circuits

regarding this very Plan and also contrary to the decisions of the Fourth, Fifth, Sixth and Seventh Circuits on this issue generally. The Ninth Circuit's decision in this case places this Plan, and any other plan which operates is in the Ninth and any of these other six federal Circuits, under directly conflicting rules regarding the administration of their plans. This result is directly contrary to Congress's goal of uniformity when it enacted ERISA. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (it is difficult to achieve ERISA's goal of a uniform administrative scheme when a plan is subject to differing regulatory requirements in different states.)

The court of appeals also held that a *per se* conflict of interest exists under *Firestone* whenever employees of the plan sponsor make decisions regarding the distribution of funds from the plan, even though those funds can never revert to the plan sponsor. This ruling is in direct conflict with at least the Eleventh Circuit regarding this very Plan and the Third, Seventh and Tenth Circuits generally. Similar to the conflict in the Circuits regarding the treating-physician rule, this conflict will subject claimants under the same Plan to different outcomes based on the same facts in cases decided by the district courts in these four Circuits. This too is directly contrary to Congress's express purpose for enacting ERISA—to apply one body of law and one set of rules to these claims. *See id.*

These conflicts will not be resolved by the courts of appeals. On both issues, the Eleventh Circuit has recently and expressly reaffirmed its position and rejected the Ninth Circuit's position in this case. The Ninth Circuit has refused *en banc* review in this case. These conflicts are not likely to abate and will continue to recur in the future. *See infra*, pp. 21-22 & 25. The only practical resolution of these issues is through review by this Court.

I. Certiorari Should Be Granted On The Question Presented Regarding The Application Of The Treating-Physician Rule To ERISA Disability Benefits Cases Because It Is A Significant Error Which Has Divided The Circuits And Requires Correction By This Court.

The Ninth Circuit in this case held that the treating-physician rule applies to ERISA-disability benefits claims. In doing so, the Ninth Circuit borrowed a Social Security Act rule which Congress had chosen not to adopt for ERISA. To compound this error, the Ninth Circuit's decision also creates a conflict with six other Circuits which places thousands of benefits plans in the untenable position of applying different rules to different participants despite the claimants' rights arising from the identical terms of a single plan. The conflict is even more egregious as it affects a statute that Congress created to provide uniform standards for plan administration, *see Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001), as evidenced by its provision preempting laws that relate to ERISA plans which this court has called "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

The result of this rule will be the transfer of much of the fiduciary/plan administrator's discretion to an individual who has no duty to fairly or uniformly administer the plan—the claimant's physician. This forced delegation runs directly counter to ERISA's imposition of a fiduciary duty on a plan administrator to administer the plan "in accordance with the documents and instruments governing the plan." *See* 29 U.S.C. § 1104(a)(1)(D).

The Ninth Circuit in this case tried to downplay the effect of giving "controlling" or "great" weight to the claimant's physician by (1) omitting those terms from its characterization of the rule, *see supra*, n.1, and (2) stat-

ing that a plan could meet the rule by giving "specific, legitimate" reasons for disagreeing with the treating physician. But its implementation of that rule flatly belies its use of neutral terms. For example, in this case the Administrative Committee specifically articulated specific and legitimate reasons for not following the opinions of Regula's two physicians. It chose not to follow the opinion of a chiropractor over the detailed opinion of a board-certified orthopaedic and rehabilitative specialist because it valued the professional expertise of an orthopaedic specialist more than that of a chiropractor. (App. *infra*, 109a.)[12] It chose not to follow the opinion of Regula's psychologist, Dr. Smith, because she had evidenced bias on Regula's behalf by criticizing *orthopaedic* conclusions of Dr. Kumar even though they were outside Dr. Smith's area of practice and because she continued to opine that Regula was disabled, but did not prescribe any of the available medications that could assist Regula. (App. *infra*, 109a.) If these reasons did not meet the Ninth Circuit's criteria for specificity and legitimacy, then the result is that the court of appeals' rule will nearly always require a plan to give controlling weight to the claimant's physician. The purported "specific, legitimate" reasons exception to the rule is undefined and illusory.

The court of appeals' adoption of this rule ignores (1) the effect of its conflict with this Court's decision in *Firestone*; and (2) the fact that its comparisons between ERISA and the Social Security Act are inapt. First, even the Ninth Circuit recognized that the application of the treating-physician rule would reduce the discretion afforded to plans under this Court's decision in *Firestone*. (App. *infra*, 17a.) It now requires (as shown by

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[12] Regula failed to explain why he chose not to submit current reports from an orthopaedist of his own choosing.

the rule's application to this case) that plans give controlling weight to a claimant's physician even when the plan administrator specifically explains that it is not persuaded by those physicians based on substantial evidence in the record, inferior credentials or bias. Application of this rule to ERISA benefits claims improperly diminishes the authority vested in this Plan pursuant to *Firestone*. (App. *infra*, 37a-40a.) (Brunetti, J. dissenting); *Dowden v. Blue Cross & Blue Shield of Tex.*, 126 F.3d 641, 644 (5th Cir. 1997).

Indeed, *Firestone's* only mention of circumstances that would diminish the discretion afforded to a plan administrator under a plan's terms involved conflicts of interest. *Firestone*, 489 U.S. at 115. It contemplates no other limits on the Plan's discretion that are not contractually based, or in the terms of the Plan, ERISA or its regulations. *Id.* As *Firestone* observed, ERISA already mandates that a plan be administered by a fiduciary. 489 U.S. at 109. However, the Ninth Circuit turns the discretionary and fiduciary aspects of *Firestone* on their respective heads by requiring a plan's fiduciary to give great weight to a physician with a fiduciary duty *to the claimant* and *no duty to the plan or its other participants*. *See Manion v. N.P.W. Med. Center of N.E. Pa.*, 676 F. Supp. 585, 588 (M.D. Pa. 1987) (medical professional's fiduciary duty is to his client).

Further, the manner in which benefits claims are to be handled by claims administrators is already subject to regulation under ERISA. 29 C.F.R. § 2560.503-1. That claims handling regulation creates no requirement that a plan administrator apply the treating-physician rule. This is not a case where it can be argued that there was room for the Ninth Circuit to create federal common law in an area neither reserved for the plan's terms nor covered by the statute or regulation. Indeed, when Congress

desired to integrate the terms of the Social Security Act and ERISA, it did so explicitly. *See* 29 U.S.C. §§ 1054(b)(1)(B)(iv), 1054(b)(1)(C), 1054(b)(1)(G); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 514-15 (1981) (same).

The court of appeals' decision in this case also erroneously draws a line between health benefits cases and disability benefits cases on the ground that physicians opining in disability cases have no financial bias in favor of claimants. As Judge Brunetti correctly points out, the treating physician is under an incentive in both sets of cases to opine favorably to the claimant. (App. *infra*, 40a); *see Pegram v. Herdrich*, 530 U.S. 211, 218 (2000) (in a fee-for-service system, the incentive is on the physician to provide more care). In the health benefits context, the requested treatment will be paid for (which produces income to the treating physician) and in the disability context, the claimant will return at the intervals required by the Plan for another examination (which also produces income to the treating physician). (App. *infra*, 40a.) Thus, the court of appeals' decision upends the playing field for plan administrators by effectively prohibiting the plan administrator from considering bias on behalf of the claimant's physician (as the Plan did in this case based on Dr. Smith's own comments), yet assumes bias on behalf of a physician hired by the Plan. (App. *infra*, 23a.)

The court of appeals' decision is also problematic because it rests on reasoning that can be readily applied to many other provisions of the Social Security Act. The court of appeals said that the treating-physician rule should apply because it would 1) force the administrator to create a better record for review and 2) increase consistency between the Social Security Act and ERISA plan disability decisions. (App. *infra*, 15a-16a.) Given

the pervasively regulated nature of Social Security claims, almost all of Social Security law fits this bill. But this consistency is not what Congress intended or else it would have required ERISA disability benefit plans to adopt standards for disability similar to the Social Security Act standard and would have otherwise extensively regulated claims process as it did with the Social Security Act. It did neither of these as ERISA was in large part intended to encourage employers to provide these additional benefits by avoiding regulatory complexity. *See Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (Congress balanced "its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place" with enhanced protection for beneficiaries).

Indeed, the end result of the Ninth Circuit's "goal" of consistency would be to require ERISA plans to follow Social Security disability decisions since ERISA plan administrators are to follow Social Security Act rules. *This "end result", however, has been rejected by not only the Ninth Circuit itself, see Madden v. ITT LTD Plan for Salaried Employees*, 914 F.2d 1279, 1286 n.6 (1990), but by many other circuits as well with respect to governmental disability programs in general. *See Delta Family-Care Disability & Survivorship Plan v. Marshall*, 258 F.3d 834, 842 n.11 (8th Cir. 2001) (under the same Plan at issue in this case, because of greater discretion granted to ERISA plan administrators, governmental disability decisions need not be followed by the Plan); *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1452 n.5 (11th Cir. 1997) (concerning Social Security); *see also Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442-43 (2d Cir. 1995) (differing standards of disability preclude similar results); *Hale v. Trustees of United Mine Workers' Health & Retirement Funds*,

23 F.3d 899, 902 (4th Cir. 1994) (same); *Brown v. Retirement Comm. of Briggs & Stratton Retirement Plan*, 797 F.2d 521, 529 (9th Cir. 1986) (same). Given that the Ninth Circuit's "goal" of consistency is (1) not what Congress desired, and (2) not attainable, the adoption of the treating-physician rule to reach the goal is contrary to law. The reasoning of the court of appeals is in error which, if left unreviewed, will lead to the further misimportation of Social Security Act law to ERISA.

As if this were not enough, the Ninth Circuit's decision stands alone among those courts of appeals that have reached this issue. All six others have rejected it. *See Elliott*, 190 F.3d at 604 (4th Cir.); *Sheppard & Enoch Pratt Hosp.*, 32 F.3d at 126 (4th Cir.); *Dowden*, 126 F.3d at 644 (5th Cir.); *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933, 938 (7th Cir. 1999); *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d at 842 (8th Cir.);[13] *Turner v. Delta Family-Care Disability and Survivorship Plan*, ___ F.3d ___, 2002 WL 1040194 *3-4 (App. *infra*, 116a) (11th Cir. Apr. 9,

[13] The Eighth Circuit has rejected the application of the treating-physician rule in ERISA cases and the court of appeals was incorrect to the extent it read Eighth Circuit law to the contrary. As Judge Brunetti noted in dissent, the Eighth Circuit (in a case involving this very Plan) did not apply the treating-physician rule in *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d at 842. The Eighth Circuit case that the Ninth Circuit cited to the contrary, *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996), did not involve a conflict of opinion between doctors who had actually examined the claimant. In fact, every doctor who examined the claimant in that case stated that claimant was disabled under FMC Corp.'s plan's definition of disability. *Id.* at 901. Given that the *non-examining* physician had previously thought that the claimant was disabled based on the opinions from the same medical professionals and then changed his mind, there was a hint in the factual circumstances of that case that the non-examining physician's opinion was not just mistaken, but disingenuous. *Id.* (To the contrary, this case involves only physicians who actually examined Regula).

2002) (per curiam); *Jett*, 890 F.2d at 1140 (11th Cir.). The Sixth Circuit also rejected the rule in its recent unpublished opinion in *Jackson v. Metropolitan Life*, 2001 WL 1450811 *2 (6th Cir. Oct. 29, 2001) (following the Eighth Circuit's opinion in *Delta Family-Care Disability & Survivorship Plan v. Marshall* and rejecting the rule). Since the court of appeals' decision in this case, the Eleventh Circuit has affirmed its rejection of the treating-physician rule and rejected *Regula's* holding by name in *Turner*, ___ F.3d at ___, 2002 WL 1040194 *3-4 (App. *infra*, 116a). In noting that the court of appeals' decision in this case is not the law of the Eleventh Circuit, *Turner, a case involving the very same benefit plan at issue in this case*, has rejected *Regula's* limitation of the Eleventh Circuit's previous decision in *Jett* to medical benefit cases only. *Id.*[14]

This is not a conflict which will be resolved by the Circuits. The Ninth Circuit has already refused to accept the case for *en banc* consideration even though it knew that it was placing this Plan in the position of interpreting its terms inconsistently with respect to its beneficiaries in the Eighth and Eleventh Circuits. This virtually guarantees that the Circuit split on this issue will remain (and likely deepen) without resolution by this Court.[15]

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[14] The claimant in *Turner* offered not to pursue a petition for a writ of certiorari or petition for rehearing in exchange for the Plan's promise not to recover its costs and fees. The Plan essentially accepted Plaintiff's offer so the decision in *Turner* is final.

[15] Many other cases which had not specifically considered the treating-physician rule, reached conclusions which foreclosed any possibility of the treating-physician rule's application. Before the court of appeals' decision in this case, it was common across the Circuits to hold that a Plan's decision was not arbitrary or capricious (or an abuse of discretion) as a matter of law when the opinions of a treating physician and of another physician who examined the claimant

In fact, the conflict already appears to be deepening. While there have been no new decisions holding that the treating-physician rule should apply to ERISA disability benefit claims cases when a plan administrator has discretion to decide disability benefit claims, two recent decisions show differing levels of potential support for the rule. The Second Circuit, in *Connors v. Connecticut General Life Insurance Corp.*, 272 F.3d 127, 135 n.4 (2001), actually rejected the treating-physician rule in a case in which *de novo* review applied, but indicated *in dicta* that it might apply the rule when the plan's terms provided the plan administrator with discretion to decide benefit claims. If the Second Circuit were to follow its *dicta* in *Connors*, it would take the odd position that plan administrators who are given discretion to decide benefits claims actually have less discretion to reject the treating physician's opinion. Further, in *Skretvedt v. E.I. Dupont de Nemours*, 268 F.3d 167, 184 (3rd Cir. 2001), the Third Circuit mentioned the treating-physician rule and cited *Regula* but there was no conflict of physician opinions in that case. While *Skredvedt* only mentions the rule in *dicta* and appears contrary to the Third Circuit's prior decision in *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 43 (3d Cir. 1993), which permitted the plan to rely on either of the conflicting physicians' opinions, it is further evidence that the split on this issue is deepening.

Further review of this case by this Court is warranted because this matter is likely to recur frequently and is not capable of resolution by the courts of appeals.

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were in conflict. *See, e.g., Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994); *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 47 (3d Cir. 1993). Even putting these cases to the side, the Ninth Circuit is the only court of appeals to have adopted the rule.

II. Certiorari Should Be Granted On The Conflict Of Interest Issue Because It Requires Different District Courts To Reach Conflicting Decisions Under The Same Plan.

The Ninth Circuit's decision in this case also conflicts with the conclusions of other circuits as it mistakenly holds that a *per se* conflict of interest exists, even if the plan irrevocably sets aside funds for the payment of benefits for its employees, when the plan sponsor's employees decide claims under the Plan. Further, while in *Firestone* this Court held that a conflict of interest would affect the degree of discretion afforded to the plan administrator, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) the Ninth Circuit has gone further in this case and held that a conflict of interest can require the application of *de novo* review. (App. *infra*, 27a). The Ninth Circuit's conclusion is also in direct conflict with a decision of the Eleventh Circuit regarding this very Plan, and the Third, Seventh and Tenth Circuits on this issue generally. Most importantly, the Eleventh Circuit considered this rule again in April of this year, in light of the Ninth Circuit's decision in this case, and affirmed that no conflict of interest existed under the same facts and involving the very same plan as this case. *See Turner v. Delta Family-Care Disability & Survivorship Plan*, ___ F.3d at ___, 2002 WL 1040194 *3 (App. *infra*, 115a-16a).

The court of appeals' holding rests on the mistaken, *per se*, assumption that a plan sponsor's employees acting in a fiduciary capacity would be more likely to deny benefits to a claimant—presumably to reduce the amount of monies that the sponsoring company needs to pay for benefit claims in the future. (App. *infra*, 26a.) But the basis for that ruling rests on nothing more than that: an

unproven, counter-intuitive assumption which has been rejected by this Court and at least four other Circuits.

First, the Ninth Circuit's *per se* approach ignores the fact that these employees are acting as plan fiduciaries, and are held to ERISA's extremely high standards requiring them to act only in the best interest of the plan participants and beneficiaries. *See* 29 U.S.C. § 1104(a)(1). It also ignores the fact that ERISA prohibits fiduciaries from acting in the best interest of the employer. *See* 29 U.S.C. § 1106(b). In fact, ERISA subjects any fiduciary who ignores these duties to *personal* liability. *See* 29 U.S.C. § 1109(a). While ERISA's fiduciary provisions require plan fiduciaries to avoid conflicts of interest, *see Mertens v. Hewitt Assoc's.*, 508 U.S. 248, 252 (1993), it permits the plan sponsor's employees to be the administrator and trustee of the plan. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 105 (1989). Thus, ERISA starts from a presumption that such an arrangement does not pose a conflict of interest.

Second, fiduciary duties aside, since a welfare benefit plan is a substitute for compensation, benefit plans are established to attract employees, *see Lockheed Corp. v. Spink*, 517 U.S. 882, 893 (1996), and pay benefits when they are due according to the Plan's terms so that placing the funding and decision-making functions in the same entity does not create a conflict of interest. "[B]enefits are a valued component of total compensation, so that the employer who is tightfisted in computing benefits, or who gets a reputation for unfairness in passing on claims, may find himself having to pay higher wages." *Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996). Courts have embraced this truism by holding that there is no conflict of interest when a plan is self-funded through contributions to a trust that are irrevocable *even if* the employer's employees decide the

claims for benefits. *See Abnathya v. Hoffmann-La Roche Inc.*, 2 F.3d 40, 43 (3d Cir. 1993); *Gallo*, 102 F.3d at 921; *Woolsey v. Marion Lab's, Inc.*, 934 F.2d 1452, 1459 (10th Cir. 1991); *Buckley v. Metropolitan Life Ins., Inc.*, 115 F.3d 936, 938 (11th Cir. 1997) (per curiam). Contrary to these decisions, the Ninth Circuit held in this case that this arrangement creates a *per se* conflict of interest. (App. *infra*, 26a.)[16] Especially when Delta had no duty to fund the Plan, *see Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995), but did so with *irrevocable* contributions, and any employer could lawfully revise a plan to reduce the amount of benefits paid should it be concerned with the amount of claims, *see Hughes Aircraft Co. v. Jacobsen*, 525 U.S. 432, 444 (1999), the Ninth Circuit's *per se* rule is illogical and contrary to law.

Like the conflict in the Circuits regarding the treating-physician rule, this conflict will not abate. In *Turner*, the Eleventh Circuit reaffirmed its rejection of the court of appeals' decision in this case and the Ninth Circuit has rejected *en banc* review. (App. *infra*, 67a-68a); *Turner*, ___ F.3d at ___, 2002 WL 1040194 *3 (App. *infra*, 115a-16a). Also, similar to the treating-physician issue, the conflict in the Circuits regarding the *per se* conflict of interest rule subjects participants under the identical terms of the same Plan to divergent results. Here, the divergent results occur when courts in different Circuits apply different standards of review to cases involving the same facts and reach different results.

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[16] Ironically, according to the court of appeals, the primary *proof* that this alleged *per se* conflict affected the Plan's decision in this case, was the plan administrator's failure to apply the treating-physician rule—a rule which had been rejected by every other court of appeals which considered this issue at the time the Plan's decision in this case was made.

Finally, as noted above, the number of participants and the dollar value of benefits at issue are tremendous when considering all plans subject to these conflicts. These differing outcomes insert an element of inherent geographic chance and unfairness into what is otherwise intended to be a uniform system of benefit payments administered by fair-minded fiduciaries. For these reasons, intervention by this Court is needed to resolve this conflict.

CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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June 12, 2002

APPENDIX

APPENDIX TABLE OF CONTENTS

PAGE

Court of Appeals Decision 1a

District Court Decision 47a

District Court Judgment 64a

Court of Appeals Order Denying Rehearing *En Banc* 67a

Statutory and Regulatory Provisions 69a

Selected Provisions of the Delta Family-Care Disability and Survivorship Plan 100a

Decision of the Administrative Committee Of Delta Air Lines, Inc..... 106a

Opinion of the United States Court of Appeals for the Eleventh Circuit, dated April 9, 2002..... 110a

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 98-55853
D.C. No. CV-96-07304-RSWL

FRANK REGULA,

Plaintiff-Appellant,

—v.—

DELTA FAMILY-CARE DISABILITY
SURVIVORSHIP PLAN,

Defendant-Appellee.

Appeal from the United States District Court
for the Central District of California
Ronald S.W. Lew, District Judge, Presiding

Argued and Submitted
October 6, 1999—Pasadena, California

Filed September 24, 2001

Before: Betty B. Fletcher, Dorothy W. Nelson,
and Melvin Brunetti, Circuit Judges.

Opinion by Judge B. Fletcher;
Dissent by Judge Brunetti

COUNSEL

Lawrence D. Rohlfing, Santa Fe Springs, California, for the plaintiff-appellant.

Hunter B. Hughes, Atlanta, Georgia, for the defendant-appellee.

OPINION

B. FLETCHER, Circuit Judge:

Frank Regula appeals the district court's denial of his motion for summary judgment on his claim that the Delta Family-Care Disability Survivorship Plan ("Delta Plan" or "Plan") abused its discretion in terminating his disability benefits. Specifically, Regula contends that the Delta Plan should have accorded deference to the opinions of his treating physicians and considered vocational evidence in making its benefits determination. Regula also sought summary judgment on the ground that the Delta Plan failed to provide him with a full and fair review of his disability claim. The district court denied Regula's summary judgment motion in its entirety and entered judgment in the Plan's favor pursuant to a stipulation signed by the parties. We vacate the judgment of the district court and remand for a determination as to whether the Delta Plan may have been acting under a conflict of interest, and thus whether the court should have applied a less deferential standard of

review to the Plan's decision to discontinue Regula's benefits.

I.

The Delta Plan is a non-contributory employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The Plan provides short- and long-term disability benefits to non-pilot Delta employees.

Under the Plan, a participating employee is eligible for short-term disability benefits "when he is disabled as a result of a demonstrable injury or disease (including mental or nervous disorders) . . . which prevents the Employee from engaging in his customary occupation." An eligible employee can qualify for short-term disability benefits for up to eighteen months with the approval of the Plan's Administrative Committee. Once the short-term disability benefits expire, a participating employee is eligible for long-term disability benefits if "he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work." An employee is eligible for longterm benefits "so long as he remains disabled." In addition, an employee must be "under the care of a physician or surgeon for the injury or disease" to remain eligible for such benefits. The Administrative Committee determines whether a participant is "disabled" and is therefore eligible for benefits.

The Administrative Committee also serves as the "named fiduciary" of the Plan and has "authority to control and manage the operation and administration of the plan." As part of its function, the Administrative Com-

mittee is given "the exclusive power to interpret [the Plan]" and "its interpretation and decisions [are] final and conclusive." Furthermore, the Committee is charged with "decid[ing] all questions concerning the Plan."

The Plan has a two-tiered review procedure governing appeals from a claims denial. The Plan's Administrative Subcommittee provides the first level of review. If the claimant is not satisfied with the outcome of the Subcommittee's decision, the claimant may then appeal to the full Administrative Committee. During either level of the review process, the claimant or his representative is entitled to review "pertinent documents relating to the denial and may submit written comments."

Frank Regula began his employment with Western Airlines ("Western") in 1971 and functioned normally in his job until sustaining "a severe injury to the neck, right shoulder and arm during the course of his employment" as a clerk in October 1985. Nearly two years later, Regula filed a claim for short-term disability benefits, claiming that he had sustained a "cervical disc injury." The Delta Plan granted Regula's request and awarded him short-term disability benefits through October 30, 1987.

The Plan then awarded Regula long-term disability benefits beginning in November 1987 and approved the continuation of these benefits on thirteen separate occasions. The Plan reviewed Regula's disability award every three months, and notified him each time that he would be required to submit an updated physician's report to prove his continued eligibility for benefits. Throughout this period, Regula continued to demonstrate his eligibility by submitting updated reports from his treating physicians. On July 25, 1995, however, the Plan terminated Regula's long-term disability benefits because it determined that he was capable of working,

rendering him ineligible for benefits under the definition of "Long Term Disability" in section 4.03 of the Plan.

Regula submitted two contemporaneous reports by his treating physicians in support of his claim for continued disability benefits.[1] In the first report, Dr. Sandra Smith, a psychologist, opined that it was "very probable" that Regula was still disabled in the summer of 1994. In response to an inquiry from the Plan about the possibility of vocational rehabilitation, Dr. Smith further clarified her diagnosis by declaring that Regula's "combined physical and emotional symptom complex" prevented him from enrolling in a vocational rehabilitation program. As a psychologist, Dr. Smith stated that her diagnosis was limited to Regula's psychological condition and that she would "defer . . . to an appropriate medical specialist concerning Regula's physical symptoms."

Regula's second report, prepared by Dr. Dean H. Cummings, provided a diagnosis of Regula's continuing physical symptoms. In that report, Dr. Cummings concluded that Regula was still "permanently disabled" in December 1994 due to the "undesirable effects of multiple surgeries." Specifically, Dr. Cummings cited Regula's "[i]nability to sustain repeated or prolonged standing, sitting, pulling, pushing, bending, stooping, lifting to waist level, lifting over [his] head, walking, exerting or sitting for 10 minutes or more" as disabling factors.

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[1] As the district court pointed out, the physicians who examined Regula during this period included Drs. Michael Smith, H. Dale Richardson, Peter Schou, Alfred Bloch, Burton Wixen, Sandra Smith, and Dean H. Cummings. By Regula's own admission, with the exceptions of Dr. Sandra Smith and Dr. Cummings, none of these physicians examined Regula within the four years prior to the Plan's 1995 termination of his long-term disability benefits. A lengthy discussion of these superannuated reports is therefore unnecessary.

In response to Regula's two reports, the Delta Plan arranged for Regula to be examined by Dr. Rajeswari Kumar, a specialist in physical and rehabilitative medicine. Dr. Kumar diagnosed Regula with chronic pain syndrome, post-traumatic pain in the cervical and lumbar regions, status post-anterior diskectomy at C5-6 and C6-7, and status post-decompression of superficial radial nerve, right upper extremity. Nevertheless, Dr. Kumar concluded that Regula was "definitely capable of gainful employment performing some type of work." Dr. Kumar also noted that Regula could perform several specific activities including, most notably, standing and walking for four to six hours per day. These considerations led Dr. Kumar to conclude that Regula was not disabled.

In addition, the Plan arranged for a psychiatrist, Dr. James O'Brien, to assess Regula's psychological condition. After examining him, Dr. O'Brien concluded that Regula was "consciously exaggerating his psychological and orthopedic difficulties." In response to the report prepared by Regula's psychologist, Dr. Smith, Dr. O'Brien specifically attacked Dr. Smith's diagnosis as biased because she expressed opinions about Regula's physical condition that were outside of her field of expertise. Consistent with Dr. Kumar's report, Dr. O'Brien also concluded that "Mr. Regula can return to work immediately and that there is no type of work within his job description that he would not be able to do." Thus, both of the Delta Plan's examiners concluded that Regula was not disabled.

Based on these reports, the Plan terminated Regula's long-term disability benefits in a letter dated July 25, 1995. The letter also notified Regula that the Plan would reconsider its decision, but that he must submit "objective evidence that [he is] continuously and totally dis-

abled from engaging in any occupation or work for compensation or profit" in order to perfect his claim.

Regula then appealed the denial of his long-term disability benefits to the Administrative Subcommittee. The Plan sent Regula's attorney, Lawrence Rohlfing, a letter informing him about a claimant's right "to review pertinent documents related to [his] appeal and submit other comments, issues or evidence in further support of the appeal to the Subcommittee." In response, Rohlfing submitted additional superannuated reports from Drs. Shapero and Smith, along with a fourpage letter setting forth Regula's legal and factual case for continued eligibility. Nevertheless, the Administrative Subcommittee rejected Regula's appeal. The Plan communicated its rejection through a letter citing specific parts of the Plan's examining physicians' reports that supported the Subcommittee's decision.

After the rejection of his appeal on the first level of review, Regula appealed to the full Administrative Committee. The Secretary of the Administrative Committee wrote a letter to Rohlfing delineating the types of evidence that could be submitted to perfect Regula's claim. This letter was received only six days prior to the scheduled date of the hearing. Recognizing that the letter did not grant Regula a sufficient amount of time to collect and submit additional evidence, the Plan offered him an extension of time. Regula refused the Plan's offer. Following a hearing, the Administrative Committee notified Regula that it was rejecting his appeal and informed him that he was no longer eligible for long-term disability benefits under the terms of the plan.

Regula subsequently filed an action against the Delta Plan in federal district court on October 17, 1996, alleging that the Plan's denial of his long-term disability benefits violated ERISA. On February 17, 1998, the district

court denied Regula's motion for summary judgment. The district court held that substantial evidence supported the Plan's decision and that the Plan did not abuse its discretion as a matter of law. In finding for the Plan, the district court rejected several arguments that it viewed as a circumvention of the broad discretion afforded to Plan Administrators. First, the district court refused to apply the "treating physician rule" in an ERISA case. Second, the district court rejected Regula's contention that the Plan's failure to consider vocational evidence was an abuse of discretion. Finally, the district court found that the Plan had conducted a full and fair review of Regula's claim.

Following the denial of Regula's summary judgment motion, the parties agreed to the following stipulation:

> TO THE HONORABLE RONALD S. W. LEW, JUDGE OF THE DISTRICT COURT:
>
> Whereas plaintiff Frank Regula filed a motion for summary judgment in the above-captioned matter on August 11, 1997, which defendant Delta Family-Care Disability and Survivorship Plan opposed;
>
> Whereas the court has issued an order denying plaintiff's motion for summary judgment;
>
> Whereas the issues at trial are identical to those issues set forth in plaintiff's motion for summary judgment and defendant's opposition thereto;
>
> Whereas of the facts before the court at trial are limited to the record before the plan administrator of defendant, consisting of the record before the court on the motion for summary judgment; and
>
> Whereas the parties wish to preserve scarce resources;

THE PARTIES HEREBY STIPULATE AND AGREE AS FOLLOWS:

If the "treating physician rule" does not apply to ERISA cases, and if the Administrative Committee's decision that plaintiff was no longer entitled to long term disability benefits was not, as a matter of law, an abuse of discretion, and if plaintiff was not denied an opportunity for full and fair review, then plaintiff cannot prevail at trial and defendant is entitled to judgment.

Plaintiff Frank Regula has preserved his rights to appeal on his contentions raised in his motion for summary judgment. The court has necessarily rejected as a matter of law each of the points raised.

Based upon the decision of the District Court, defendant is entitled to judgment.

IT IS SO STIPULATED.

The district court approved the stipulation by entering judgment. Regula then filed this appeal pursuant to 28 U.S.C. § 1291, which grants this court appellate jurisdiction over a final decision of the district court.

II.

A district court's denial of summary judgment is ordinarily not appealable. *California v. Campbell*, 138 F.3d 784, 786 (9th Cir. 1998); *see also Behrens v. Pelletier*, 516 U.S. 299, 306-07 (1996) (holding that a denial of immunity is within a small class of cases that are immediately appealable from a denial of summary judgment). The so-called final judgment rule allows parties to appeal only final decisions of the district courts. *See* 28 U.S.C. § 1291. A final judgment is " 'a decision by the

District Court that ends the litigation on the merits and leaves nothing for the court to do but execute the judgment.' " *Dannenberg v. Software Toolworks Inc.*, 16 F.3d 1073, 1074 (9th Cir. 1994) (quoting *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 467 (1978)). The purpose of the final judgment rule is to ensure that all claims are raised in a single appeal to avoid piecemeal adjudication of a single controversy. *See Cobbledick v. United States*, 309 U.S. 323, 325 (1940).

As an appellate court, we are required to raise the finality of the district court's order sua sponte on appeal. *See In re Exennium, Inc.*, 715 F.2d 1401, 1402 (9th Cir. 1983). As we noted in *Dannenberg*, this court takes a "pragmatic approach to finality," and there are situations when a stipulated judgment may fulfill the purposes underlying the final judgment rule. 16 F.3d at 1075. These limited cases arise only when all the claims that may be the subject of an appeal have become sufficiently finalized. *See id.* Thus, although the parties in this case stipulated to the judgment, we have jurisdiction only if the stipulated judgment sufficiently finalized the district court's order denying Regula's summary judgment motion. We conclude that the stipulated judgment so finalized Regula's appeal.

The district court's denial of Regula's motion for summary judgment conclusively decided the legal and factual issues in the case. As stated in the stipulation, the parties agreed that Regula could not prevail at trial after the denial of his summary judgment motion. Accordingly, the parties stipulated to the judgment to facilitate the immediate appeal of an ordinarily nonappealable order in an effort to "preserve scarce resources." The stipulation placed all the issues before this court for de novo review, preserving resources because there were no undecided issues that could subject this court to the

threat of piecemeal adjudication through multiple appeals. The district court then properly finalized the stipulation by entering judgment in favor of the Plan.

In a nearly identical case, we held that parties may stipulate to a final judgment if all the issues in the case are placed in this court on appeal. *See Comsource Independent Foodservice Cos. v. Union Pacific Railroad Co.*, 102 F.3d 438 (9th Cir. 1996). In *Comsource*, the defendants filed a summary judgment motion, claiming that the plaintiff's cause of action was barred by the statute of limitations. *See id.* Although the district court denied summary judgment, the parties stipulated to a final judgment for the purpose of facilitating an appeal. *See id.* As in this case, all the issues in Comsource were decided by the district court and placed in this court for de novo review. The stipulation turned a nonfinal order—the denial of a summary judgment motion—into a final judgment by virtue of an agreement between the parties and subsequent approval by the district court through an entry of judgment. *See id.* The procedure set forth in Comsource directly controls the jurisdictional question in this case.[2]

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[2] The cases of *Dannenberg* and *Cheng v. Commissioner*, 878 F.2d 306 (9th Cir. 1989), are not to the contrary. Both cases are distinguishable because they involved a district court's *grant* of partial summary judgment rather than the *denial* of summary judgment. *See Dannenberg*, 16 F.3d at 1074; *Cheng*, 878 F.2d at 308. In both *Dannenberg* and *Cheng*, the parties stipulated to a final judgment on all claims, including those that were unaffected by the district court's grant of partial summary judgment. *See Dannenberg*, 16 F.3d at 1074 (stipulating to the dismissal of all claims including a Section 11 claim arising under the Securities Act of 1933 even though it was unaffected by the grant of partial summary judgment); Cheng, 878 F.2d at 308 (stipulating to the disallowance of all of a taxpayer's claimed tax deductions even though some were left undisturbed by the district court's grant of partial summary judgment). However, the unadjudicated claims could not properly be brought on appeal. *See*

Thus, under the controlling authority of *Comsource*, we have jurisdiction over this matter pursuant to 28 U.S.C. § 1291. The scope of our review is limited to the district court's denial of summary judgment. *See Comsource*, 102 F.3d at 442.

III.

We review a district court's denial of summary judgment de novo. *See Moran v. Washington*, 147 F.3d 839, 844 (9th Cir. 1998). On review of summary judgment, we must determine whether the evidence, when viewed in a light most favorable to the nonmoving party, raises any genuine issues of material fact and whether the district court correctly applied the substantive law. *See Berry v. Valence Tech., Inc.*, 175 F.3d 699, 703 (9th Cir. 1999). We also review de novo the district court's choice and application of the standard of review applicable to decisions of plan administrators in the ERISA context. *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 797 (9th Cir. 1997).

Due to the unusual posture in which this case has come before us, we make special note to address the parties' stipulation, which has been ratified by the district court. The parties have stipulated to the abuse of discretion standard following the district court's ruling. This stipulation was undertaken by the parties with the apparent purpose of granting finality to the ruling of the

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Dannenberg, 16 F.3d at 1076; *Cheng*, 878 F.2d at 310. In contrast to Comsource, the proper procedure in *Dannenberg* and *Cheng* was for the parties to obtain Rule 54(b) certification from the district court because there were undecided claims not subject to appeal. The parties in each case failed to do so, and we properly dismissed their appeals to prevent piecemeal adjudication of their claims. *See Dannenberg*, 16 F.3d at 1078; *Cheng*, 878 F.2d at 310-11.

district court on summary judgment. However, the decision of the parties to set aside issues of law does not affect the scope of our review.

As an appellate court, we are not bound by stipulations as to questions of law. *Estate of Sanford v. Commissioner of Internal Revenue*, 308 U.S. 39, 51 (1939); *Swift & Co. v. Hocking Valley Ry. Co.*, 243 U.S. 281, 289-290 (1917) (stating that a stipulation intended to be "treated as an agreement concerning the legal effect of admitted facts . . . is obviously inoperative; since the court cannot be controlled by agreement of counsel on a subsidiary question of law"). An appellate court "act[s] without any impropriety in refusing to accept what in effect [is] a stipulation on a question of law." *United States Nat'l Bank of Oregon v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 448 (1993). Furthermore, the Supreme Court has stated that "a court of appeals does not abuse its discretion when it raises the validity of a law even when the parties failed to raise the issue in the briefs or before the district court." *United States v. Alameda Gateway Ltd.*, 213 F.3d 1161, 1167 (9th Cir. 2000) (citing *Nat'l Bank of Oregon*, 508 U.S. at 448).

For reasons discussed below, we set aside the parties' stipulation as to the appropriate standard of review and remand to the district court for further proceedings.

A.

Defining the proper standard of review to apply to the administrator's benefits determination is, of course, critical to determining the outcome here. The parties' stipulation is suggestive of how it might be critical, but again not dispositive on the issue of what the standard in fact should be or how it ought to be applied. Judge Brunetti hypothesizes in his dissent that, by stipulating

to an abuse of discretion standard, the parties have implicitly stipulated that the administrator's decisions were not impaired by a conflict of interest. Dissent at 13511. We reject this interpretation for several reasons. First, the record below is insufficiently developed, and the language of the stipulation insufficiently rich, for us to infer such a crucial point. Because the district court did not solicit arguments concerning the apparent existence of a conflict, the parties' views on the subject are impossible to determine. There is no indication that the stipulation was entered in order to restrict our appellate review of the facts of this case beyond the restrictions ordinarily placed on the review of a ruling on summary judgment.[3]

Second, as discussed in greater detail below, our precedent in the area of ERISA disability determinations refers to both a highly deferential and a less deferential standard of review by the same term, "abuse of discretion."[4] Precisely because the degree of deference owed to the decision maker is split within the standard according to the factual conditions under which the standard is

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[3] Rather, the statement by the parties that they wished, by entering the stipulation, "to preserve scare resources" seems to indicate only that the stipulation was intended to reduce the public and private costs of further litigation at the district court level.

[4] *See* below at Section II.B. In this sense, the term defines not an absolute degree of deference but a mode of review, meaning that we review the determination of the decision maker to ascertain its reasonableness, according to the evidence before it at the time that the determination was made, and without the benefit of hindsight. *See, e.g., Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1472 (9th Cir. 1993) (overruling a finding by the district court based on its review of evidence not before the plan administrator, because the review of such evidence under an abuse of discretion standard would lead "to the anomalous conclusion that a plan administrator abused its discretion by failing to consider evidence not before it").

to be applied, stipulation to the standard cannot be said to imply agreement as to the crucial factual predicate upon which the degree of deference turns.

Third, and diametrical to the dissent's position, we might infer from the parties' choice to place the treating physician rule at the center of this controversy that, without recourse to such a rule, the appellant would be denied even a threshold opportunity to examine the sufficiency of the Plan's reasons for terminating benefits, precisely because the Plan would be under no duty either to make their reasons specific or to base them on substantial evidence. We do not agree that this inference should guide our decision either, in part because we do not assume that the abuse of discretion standard under ERISA is necessarily incompatible with importation of the treating physician rule.

The treating physician rule applied in the Social Security setting requires that the administrative law judge ("ALJ") determining the claimant's eligibility for benefits give deference to the opinions of the claimant's treating physician, because "he is employed to cure and has a greater opportunity to know and observe the patient as an individual." *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999); *see also Smolen v. Chater*, 80 F.3d 1273, 1285 (9th Cir. 1996). This grant of deference to a treating physician's opinions increases the accuracy of disability determinations, by forcing the ALJ who rejects those opinions to come forward with specific reasons for his decision, based on substantial evidence in the record. Just as in the Social Security context, the disputed issue in ERISA disability determinations concerns whether the facts of the beneficiary's case entitle him to benefits. Therefore, for reasons having to do with common sense as well as consistency in our review of disability determinations

where benefits are protected by federal law, we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions.[5]

The dissent rejects this comparison on the belief that "a disability determination under ERISA is subject almost entirely to the plan's language." Dissent at 13515. The dissent further contends that adaptation of the treating physician rule to ERISA would impermissibly erode the discretion granted to a plan administrator under the terms of a lawful benefits contract. Dissent at 13515. We disagree with both of these propositions.

First, we note that the deference given to a treating physician's opinions under the rule is not absolute. "When a nontreating physician's opinion contradicts that of the treating physician—but is not based on indepen-

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[5] In deciding this issue of first impression in this circuit, we are mindful of the fact that other circuits appear divided on this issue. The only circuit explicitly to rule on the issue has held that the treating physician rule does apply to ERISA disability cases. *See Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996) ("We have held, in Social Security cases, that a reviewing physician's opinion is generally accorded less deference than that of a treating physician . . . and we apply this rule in disability cases under ERISA as well.") *But see Delta Family-Care Disability & Survivorship Plan v. Marshall*, 258 F.3d 834, 842-43 (8th Cir. 2001) (distinguishing *Donaho* on the grounds that, although the record contained conflicting medical opinions regarding the beneficiary's disability, the plan administrator did not abuse its discretion by terminating benefits where that decision was supported by substantial evidence). At least one other circuit has, in dicta, expressed doubts about the rule's applicability in the ERISA disability context. *See Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999) (concluding that it was "not persuaded" to apply the treating physician rule to the ERISA disability claim at issue, but determining that it need not reach the question because even if the rule applied, persuasive contradictory evidence existed to discount the opinion of the one treating physician who had expressed doubt as to whether the claimant could return to work).

dent clinical findings, or rests on clinical findings also considered by the treating physician—the opinion of the treating physician may be rejected only if the ALJ gives 'specific, legitimate reasons for doing so that are based on substantial evidence in the record.' " *Morgan*, 169 F.3d at 600 (quoting *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995). "[I]f the treating physician['s] opinions are uncontroverted, those reasons must be clear and convincing." *Smolen*, 80 F.3d at 1285. The opinions of a nonexamining (or reviewing) physician may serve as substantial evidence under the rule, when they are supported by other evidence in the record and consistent with the evidence in the record overall. *See Shalala*, 53 F.3d at 1041. Therefore, the discretion of the plan administrator would be no more abrogated by compliance with the treating physician rule than it ought to be under a statute the purpose of which is at least in part "to promote the interests of employees and their beneficiaries." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983).

Second, we reject the view that disability determinations under ERISA are determined almost exclusively by plan language because we believe that this misstates the true role of plan language in determining our standard of review. The Supreme Court has held that our review of benefits determinations by an insurer will be for abuse of discretion when the plan language designates discretion to make such determinations and to interpret eligibility with the plan administrator. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). This ruling, however, does not indicate precisely *how* reviewing courts ought to assess the reasonableness of an administrator's determinations, only that ruling upon compliance with ERISA requires such an assessment.

Furthermore, we do not believe that the treating physician rule is inconsistent with the broad discretion accorded plan administrators under *Firestone*. Indeed, it is inaccurate to say that disability determinations under ERISA are almost entirely subject to the plan's language.[6] While this statement may be presumptively correct with respect to a plan administrator's authority to interpret the *terms* of a plan, in the context of a disability claim such as Regula's, the key issue in determining whether a claimant is entitled to benefits is not the language of the plan, but the facts of the particular case. Hence, just as in Social Security cases, the issue in dispute in this case is not the meaning of the terms of the plan but whether the facts of Regula's case entitle him to benefits. As with Social Security cases, eligibility for benefits turns almost entirely on medical professionals' opinions as to the claimant's impairments and residual capacity (*i.e.*, whether or not Regula's condition prevents him from performing "any occupation").

Like the plan administrator under ERISA, the ALJ is given broad discretion to determine eligibility for disability benefits under the Social Security Act ("SSA"). Courts review these determinations under an abuse of

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[6] *McKenzie v. General Telephone Co. of California*, 41 F.3d 1310 (9th Cir. 1994), is not to the contrary. *McKenzie* held that vocational evidence "is unnecessary where the evidence in the administrative record supports the conclusion that the claimant does not have an impairment which would prevent him from performing some identifiable job." 41 F.3d at 1317. *McKenzie* did *not* hold that vocational evidence would *never* be required, but simply that "the plan administrator is not required in *every case* where the 'any occupation' standard is applicable to collect vocational evidence in order to prove there are available occupations for the claimant." *Id.* (emphasis added). Thus, *McKenzie* does not stand for the proposition that Social Security disability cases are fundamentally different from ERISA cases or that "extraneous" terms should not be read into ERISA plans.

discretion standard, and the treating physician rule assists in this review by ensuring that the ALJ's decisions are based upon substantial evidence. It has long been settled among the circuit courts that disability determinations under SSA will be guided by the treating physician rule. *See Murray v. Heckler,* 722 F.2d 499, 501 (9th Cir. 1983) (joining the Second, Fifth, and Sixth Circuits in holding that the treating physician's opinions should be accorded greater weight than that of an examining or reviewing physician). The Social Security Administration subsequently codified the treating physician rule in its regulations governing disability determinations. *See* 20 C.F.R. §§ 404.1527(d), 416.927(d) (2001).

Under ERISA, the plan administrator is similarly charged with the task of making accurate disability determinations and those determinations are reviewable by courts in order to ensure that they are based upon appropriate and substantial evidence. *See Eley v. Boeing Co.*, 945 F.2d 276, 278 n.1 (9th Cir. 1991) (clarifying that the abuse of discretion standard under ERISA requires the plan administrator to support its decisions by "substantial evidence"). Review of the sufficiency of evidence supporting a plan administrator's disability determinations, as well as the consistency of the administrator's actions in dealing with the beneficiary, have long been a part of our review of disability determinations pursuant to the ERISA abuse of discretion standard. To the degree that the treating physician rule can assist courts to enforce the accuracy of disability determinations under ERISA, we find no reason why the rule should not be adapted to that context.

The dissent further complains that adaptation of the treating physician rule to the ERISA context is beyond our judicial authority because Congress has implicitly

excepted disability determinations under ERISA from compliance with the rule. The dissent argues that, because the rule has been codified under the Social Security Act and yet Congress failed to codify it under ERISA, congressional inaction should be interpreted as a rejection of the rule's propriety in the ERISA context. Dissent at 13515. This argument is based upon a false assessment of the genesis of both the standard of judicial review under ERISA and the treating physician rule under the Social Security Act.

In responding to the dissent, it is important to recognize that ERISA itself does not designate a particular standard for judicial review of plan administrators' disability determinations. Instead that standard was designated by the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, *supra*, according to its interpretation of the purposes of the statute. In *Firestone*, the Court stated that "ERISA was enacted 'to promote the interests of employees and their beneficiaries' and 'to protect contractually defined benefits.' " 489 U.S. at 113 (citation omitted) (quoting *Shaw*, 463 U.S. at 90, and *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)). It is for the latter reason that the Court adopted the abuse of discretion standard where plan language ceded discretion to the plan administrator to determine benefits and interpret contractual language. *Id.* at 115. We address the standard established by the *Firestone* decision in greater detail below. For the moment, it is most important to note that the Court's ruling was intended to reconcile the joint objectives of the statute (rather than to satisfy one to the exclusion of the other) while simultaneously interpreting the provisions of ERISA in order to maintain their consistency with"other settled principles" of law. *Id.* at 112.

Before fashioning this compromise, the Court first had to address the argument that to determine independently a standard of review was beyond its institutional authority. The petitioner *Firestone* had argued that, because Congress failed to pass a bill that would have overturned circuit court precedent applying an arbitrary and capricious standard to ERISA claims, such inaction indicated that Congress itself agreed with the application of that standard. *Id.* at 114. The Court disagreed, stating that "[t]hough 'instructive,' failure to act on the proposed bill is not conclusive of Congress' views on the appropriate standard of review." *Id.* In adjudicating between the arbitrary and capricious and de novo standards advocated by the parties, the Court concluded that the question of what standard to apply would turn partially upon plan language. It further modified this rule, in order to preserve its consistency with established principles of trust law, by stating that, even where plan language places discretion with the administrator, a conflict of interest "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' " *Id.* at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)).

We face a similar problem in the present case. As recognized by other circuit courts, the abuse of discretion standard under ERISA has yet to be developed enough to provide a consistent, "across-the-board test" for reviewing disability determinations. *See, e.g., Donaho v. FMC Corp.*, 74 F.3d 894, 899 (8th Cir. 1996). In particular, we do not believe that ERISA dictates that the standard should lack *any* degree of specific tailoring to the task of determining disability. Moreover, we reject the argument that Social Security disability determinations are distinguished by the fact that Congress and the Social Secu-

rity Administration created an elaborate statutory and regulatory scheme governing such determinations.

In enacting ERISA, Congress also created an elaborate regime of laws and regulations governing covered benefit plans in order to protect the rights of participants and their beneficiaries. 29 U.S.C. § 1001(b) (2000). A guiding principle such as the treating physician rule that is effective in helping plan administrators make fair and accurate disability determinations is consistent with this goal. Therefore, even assuming that the Social Security scheme is somehow more "elaborate" than ERISA, that alone is insufficient reason to decline to adopt the treating physician rule.

We note that two other circuits have declined to apply the treating physician rule to ERISA health benefits determinations. *See Salley v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (stating in dicta that the court has "considerable doubt about holding the [treating physician] rule applicable in ERISA cases."); *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989) (stating that even a plan's failure to contact a treating physician is not an abuse of discretion); *see also Sheppard v. Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994) (rejecting the treating physician rule when an ERISA plan is making a determination about the medical necessity of a prescribed treatment). It is worth emphasizing, however, that *Salley*, *Jett* and *Sheppard* all involved disputes over health care—rather than disability—benefits. This distinction is critical, given that the sole rationale for rejecting the rule advanced by these holdings is that a treating physician may be operating under a conflict of interest. *See, e.g.*, *Salley*, 966 F.2d at 1016 ("[T]he treating physician would stand to profit greatly if the court were to find benefits should not be terminated.") (citing

Jett, 890 F.2d at 1140)). Unlike health insurance benefits, which are paid directly to the treating physician, disability insurance benefits serve as a salary replacement payable to the employee. Thus, any potential conflict of interest in ERISA disability cases is no different from that which may exist in the Social Security context, where we have long found the treating physician rule to be applicable.

Indeed, far more troubling is the conflict of interest inherent when benefit plans repeatedly hire particular physicians as experts. Especially in cases such as this one, where the plan administrator is also the funding source, these experts have a clear incentive to make a finding of "not disabled" in order to save their employers money and to preserve their own consulting arrangements. None of the appellate courts deciding that the treating physician rule should not apply to health benefits determinations addressed the relevance of either potential conflict of interest.

Whereas differences exist between ERISA and Social Security in the discretion afforded plan administrators and ALJs in interpreting the terms of benefits coverage, we are not convinced that their roles differ significantly when it comes to deciding whether the facts of a particular case fall within clearly established definitions of what constitutes a disability.[7] As in the Social Security

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[7] Social Security ALJs also have broad discretion in deciding whether the facts support a finding of disability. *See Allen v. Heckler*, 749 F.2d 577, 579 (9th Cir. 1985) ("Where medical testimony is conflicting . . . it is the ALJ's role to determine credibility and to resolve the conflict."); *Allen v. Sec'y of Health & Human Servs.*, 726 F.2d 1470, 1473 (9th Cir. 1984) ("It is the ALJ's role to resolve evidentiary conflicts. If there is more than one rational interpretation of the evidence, the ALJ's conclusion must be upheld."). At the same time, as with ALJs, the discretion of plan administrators is not unfettered. For example, plan administrators are required to obtain relevant

disability context, a rule requiring plan administrators to give special weight to the opinions of treating physicians is a similarly common sense requirement that, while inconsistent with the exercise of *absolute* discretion, is perfectly consistent with the plan administrator's role in properly determining whether a particular claimant is disabled.

In the present case, given our need to remand for a determination as to whether the Delta Plan may have been operating under a conflict of interest, the scope of the plan administrator's discretionary authority may not be so broad in the first place. Given the apparent existence of a conflict, we cannot agree that the issue of what standard to apply to Delta's determination has been settled either by the parties' stipulation or by the district court's ruling. Therefore, we can make no final ruling as to whether the plan administrator abused its discretion when it terminated Regula's disability benefits. Instead, we are properly concerned with the question of whether the district court improvidently ignored evidence that was before it at the time of summary judgment and that was material to the determination of an appropriate standard of review. For reasons discussed below, we conclude that the district court erred in this regard, and we remand for a proper determination as to the administrator's impairment due to a conflict of interest.

B.

We review de novo the decision of a plan administrator to deny benefits "unless the benefit plan gives the

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medical evidence to guide their decisions. *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1015 (5th Cir. 1992) (holding that the plan administrator abused its discretion by failing to obtain necessary medical information).

administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone*, 489 U.S. at 115; *see also Tremain v. Bell Industries, Inc.*, 196 F.3d 970 (9th Cir. 1999). When the plan's language confers such discretion, we review the decision of the administrator under an abuse of discretion standard. *Tremain*, 196 F.3d at 976.

In this case, the Plan's language appears to grant the Administrative Committee the broadest possible discretion in determining benefits eligibility:

> The Administrative Committee shall have the broadest discretionary authority permitted under the law in the exercise of all its functions, including, but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder but shall act in an impartial and non-discriminatory manner with respect thereto.

The Administrative Committee also has "the exclusive power to interpret" the Plan and "its interpretation and decisions [are] final and conclusive." Finally, the Administrative Committee is empowered to "decide all questions concerning the Plan."

Nevertheless, the fact that the terms of the Plan vest the administrator with broad discretionary authority does not end our inquiry. In *Firestone*, the Supreme Court ruled that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' " *Id.* at 115; *see also Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996). We have held that our review in such cases is "still for abuse of discretion, [but it] is 'less deferential.' " *Tremain*, 196 F.3d at 976.

At the time of its ruling, the district court had before it Plan documents indicating that all of the members of the Administrative Committee were appointed by the Delta Board of Directors. Furthermore, although the benefit fund was organized as a trust, it was funded exclusively by Delta companies based on actuarial data. Thus, Delta effectively acted as both administrator and funding source for the Plan.

These factors formed the basis of our decision in *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc.*, *supra*, where we held that an insurer's "conflict of interest, arising out of its dual role as the administrator and funding source for the Plan, affected its decision in Lang's case." *Id.* at 796; *see also Tremain*, 196 F.3d at 976-77 (finding a conflict of interest under similar circumstances). The *Lang* court approvingly cited the Eleventh Circuit's decision in *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991), for the proposition that "plans such as this one, funded by insurers and also administered by them, are not true trusts." *Lang*, 125 F.3d at 798 (citing *Brown*, 898 F.2d at 1567); *see also Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 86-87 (4th Cir. 1993) ("Even the most careful and sensitive fiduciary [when operating under a conflict of interest] may unconsciously favor its profit interest over the interests of the plan, leaving beneficiaries less protected than when the trustee acts without self-interest and solely for the benefit of the plan."). Under such circumstances, plan benefits decisions are subject to a less deferential standard of review.

This "less deferential" standard consists of two steps:

> First, we must determine whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tend-

> ing to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary. If not, we apply our traditional abuse of discretion review. On the other hand, if the beneficiary has made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317, 1323 (9th Cir. 1995). By providing material, probative evidence of a conflict, the plan beneficiary creates a rebuttable presumption that the plan's decision was in fact a dereliction of its fiduciary responsibilities. The plan then "bears the burden of rebutting the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits." *Lang*, 125 F.3d at 798. If the plan fails to carry its burden, then we review de novo its decision denying benefits. *Tremain*, 196 F.3d at 976.

Because in this case Delta acted as both administrator and funding source for the plan, and evidence of this conflict was before the district court at the time of summary judgment, the district court should have determined whether the apparent conflict of interest was indeed serious enough to have resulted in a breach of fiduciary duty before choosing the appropriate standard of review to be applied to the Plan's disability determinations. Thus, the court erred in failing even to consider whether Regula provided or could provide material, probative evidence of a breach of fiduciary duty. Instead the court simply concluded from the language of the Plan that an abuse of discretion standard applied, and then permitted the parties to enter into a stipulation presuming that this highly deferential standard was incontro-

vertibly the appropriate standard of review. *Cf. Lang*, 125 F.3d at 799-800 ("The district court did not conduct the appropriate conflict of interest analysis and hence accorded [the insurer] a deference to which it was not entitled.") This conclusion was premature, and, as a result, this case has arrived for our review with an extremely unusual and infelicitous posture.

C.

We stated at the outset that, if the district court proceedings had not been curtailed by the parties' stipulation, we may well have been able to determine the proper standard for the judicial review of the Plan's termination of Regula's disability benefits. However, under the present posture, such a determination by this court would be both premature and prejudicial, since the judicial assessment of an apparent conflict is managed through a burden-shifting scheme and the parties in this case, while presenting some relevant evidence for our review, have not been permitted the opportunity to make thoroughly responsive arguments regarding the fulfillment of their burdens. Still, we do not conclude that the district court must restart this process from scratch.

As stated above, a plan will be viewed as operating under an apparent conflict when it is both funded and administered by the insurer. In the present case, Delta both funds and administers the Plan. However, de novo review of a plan that gives discretion to an administrator remains inappropriate unless the plan beneficiary comes forward with material, probative evidence "tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood*, 45 F.3d at 1323.

In *Lang*, we ruled that evidence of inconsistency in the administrator's dealings with the beneficiary was material evidence of its self-interested behavior and grounds for ultimately reinstating benefits. The evidence of inconsistency in that case regarded a series of events in which the defendant plan first denied disability benefits because the beneficiary lacked evidence of a physical ailment and later, when confronted with an uncontroverted diagnosis by her treating physician that the beneficiary had fibromyalgia, continued to withhold benefits pending proof that the physical ailment alone was the cause of her disability. 125 F.3d at 799; *see also Brown*, 898 F.2d at 1569 (finding evidence of inconsistency in the administrator's reversal of a payment decision for only one of two related claims on the basis of no new evidence). In *Tremain v. Bell Industries*, *supra*, we held that a plaintiff beneficiary established material, probative evidence of a conflict of interest where the plan administrator appeared to have relied upon an improper definition of disability in processing the beneficiary's claim and where the administrator announced a determination of the beneficiary's earning capacity for which it provided no supporting evidence. 196 F.3d at 977.

Here, we find a similarly unsettling pattern of inconsistency and insufficiency in the plan administrator's reasons for terminating the appellant's benefits. First, the Plan's sudden termination of Regula's benefits came abruptly, with no evidence alleged of a significant change in his condition. This point is significant because the Plan had otherwise maintained the appellant's long-term benefits for almost eight consecutive years, while reviewing his claim regularly at three month intervals. Second, and more importantly, once Regula appealed the Plan's decision, the Plan based its final determination upon reports provided by examining physicians whose

diagnoses contradicted those of Regula's own treating physicians and to whom Regula had been referred by the Plan in response to the medical reports that Regula produced during his appeal. We note that the plan's examining doctors contradicted the treating physicians on issues that the latter themselves had considered, and (with the single exception of the criticism made about Dr. Smith's expertise) without providing specific reasons for their disagreement.

We cannot find that the Plan's sudden and thinly supported departure from the prevailing diagnosis offered by Regula's doctors was either consistent or sufficiently supported by the record. Furthermore, we find that, in light of the Plan's apparent conflict of interest, the administrator's decision to reject the opinions of the appellant's treating physicians constitutes material, probative evidence of a conflict. On this point, we add deviation from the treating physician rule to the short list of factors by which a court may determine that an apparent conflict of interest has ripened into an actual, serious conflict, thereby permitting the court to engage in de novo review. Of course, the Plan could rebut this evidence by showing that its termination decision was supported by specific, legitimate reasons that are based on substantial evidence in the record. In this sense, our ruling resembles the treating physician doctrine found in the Social Security context. *Cf. Morgan*, 169 F.3d at 600. However, because the district court concluded that the treating physician rule did not apply in the ERISA context, it did not provide the parties with an opportunity to complete this burden-shifting analysis.

We conclude that the proper standard of review to be applied to the plan administrator's decision in this case can only be determined after an appropriate determination has been made in the district court regarding the

Plan's apparent compromise due to a conflict of interest. Therefore, we remand to the district court for a proper finding on this issue. On remand, we direct the district court to receive and consider additional evidence regarding Delta's apparent conflict of interest, so as "to enable the full exercise of informed and independent judgment." *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 943 (9th Cir. 1995). When examining the evidence for a conflict of interest, the district court is not limited to the administrative record before the plan administrator at the time that the benefits determination was made. *Tremain*, 196 F.3d at 977. In addition, we note that, since we have already determined by our own review of summary judgment that the appellant did establish material, probative evidence of a conflict, the burden now falls upon the Plan to rebut the presumption that it was acting under a conflict.

VACATED AND REMANDED.

BRUNETTI, Senior Circuit Judge, dissenting:

I dissent from part III of the majority's opinion.

I.

In this case, the district court reviewed the decision terminating Regula's disability benefits, by Delta's ERISA Plan Administrator, for an abuse of discretion. The abuse of discretion standard was applied for good reason—the parties stipulated to this standard of review. Nowhere in the briefs does either party argue that a different standard should apply. In fact, Regula's opening

brief states that "Plaintiff conceded in the District Court that it reviews factual determinations for abuse of discretion." Opening Brief at 11. The parties' stipulation is in complete accord with the Plan's language, which states that:

> The Administrative Committee shall have the broadest discretionary authority permitted under the law in the exercise of all its functions, including, but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder but shall act in an impartial and non-discriminatory manner with respect thereto.

The Administrative Committee is also granted "the exclusive power to interpret" the Plan, its interpretation and decisions being "final and conclusive." However, the majority now holds that before applying this standard of review in accordance with the stipulation, the district court should have determined whether the Plan was operating under a conflict of interest.

There is no doubt that where a conflict of interest is found to exist, the plan administrator's decision is afforded less deference. *See Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999). But that is not the factual record in this case. Regula made no such claim, offered no such proof, and has stated to the contrary by stipulation to the abuse of discretion standard of review. *See Atwood v. Newmont Gold Co.*, Inc., 45 F.3d 1317, 1323-23 (9th Cir. 1995) ("We ultimately apply a traditional abuse of discretion standard to the decisions of apparently conflicted employer- or insurer-fiduciaries *unless* the affected beneficiary comes forward with further evidence indicating that the conflicting interest caused a breach of the administrator's fiduciary

duty to the beneficiary."). The majority opinion has reached out and created a new case for Regula that never existed. I do not agree with the majority's determination that although the parties' stipulation to abuse of discretion review acts as a waiver, this court is under an obligation to, sua sponte, order an evidentiary hearing to *see* whether there was indeed a conflict of interest.

The majority cites *Estate of Sanford v. Comm'r of Internal Revenue*, 308 U.S. 39 (1939) and *U.S. v. Alameda Gateway Ltd.*, 213 F.3d 1161 (9th Cir. 2000) for the proposition that we are not bound to accept the parties' stipulation as to the abuse of discretion standard. I disagree. In *Estate of Sanford*, 308 U.S. at 50, the parties stipulated to an interpretation of the gift taxing *statutes* at issue. The Supreme Court refused to be bound by the stipulation, holding that "[w]e are not bound to accept, as controlling, stipulations as to questions of law." *Id.* at 51. In *Alameda Gateway Ltd.*, in the context of noncompliance with an agency statement that was not binding on the agency, this court stated that "the Supreme Court has recognized that a court of appeals does not abuse its discretion when it raises the validity of a law even when the parties failed to raise the issue in the briefs or before the district court. *See id.* at 1167 (citations omitted). This Court observed that the Supreme Court carved out an exception to the general rule of waiver, stating 'that the Court of Appeals acted without any impropriety in refusing to accept what in effect was a stipulation on a question of law.' " *See id.* (citing *United States Nat'l Bank of Oregon v. Independent Ins. Agents of Am.*, 508 U.S. 439, 448 (1993). Notably, this exception was applied where we found ourselves with the "unsavory prospect of *reviewing a regulation* that may not have the force of law and which our case law specifically precludes us from reviewing." *See*

id. at 1168 (emphasis added). Furthermore, in *United States Nat'l Bank of Oregon*, 508 U.S. at 447-48, cited by this court in *Alameda Gateway Ltd.*, 213 F.3d at 1167-68, the Supreme Court held that the court of appeals had a duty to, sua sponte, inquire into the validity of a *statute* that had thought to have been repealed. What all of these cases have in common is that through stipulation or waiver, federal courts found themselves in the precarious position of possibly having to *apply a law* or an *interpretation of a law* that by its very nature is invalid.

Our situation is different because the parties did not stipulate to a question of law in its ordinary sense. No one is arguing here that a law is invalid or that a particular meaning should be given to the phrase "abuse of discretion." Rather, the parties stipulated to a *standard of review*, which, unlike the cases mentioned, had the effect of waiving questions of fact, not a question of law. The parties could have stipulated before the district court that the Plan Administrator was not operating under a conflict of interest, a factual determination. This, together with the indisputably broad discretionary power granted to the Plan Administrator, would have unquestionably resulted in an abuse of discretion standard of review. By stipulating, instead, to the abuse of discretion standard of review, the parties have implicitly stipulated to the question of fact that the Plan Administrator was not operating under a conflict of interest. Regula has never argued or set forth a contrary position at any point in the proceedings, including his briefs to this Court. *See Atwood*, 45 F.3d at 1323-23. Thus, I believe that the district court correctly applied the abuse of discretion standard.

II.

A.

Reviewing the Plan Administrator's decision for an abuse of discretion, I would affirm the district court. Regula first contends that the Plan abused its discretion as a matter of law because it failed to consider vocational evidence in evaluating Regula's claim. However, under the "any occupation" standard, the "consideration of vocational evidence is unnecessary where the evidence in the administrative record supports the conclusion that the claimant does not have an impairment which would prevent him from performing some identifiable job." *McKenzie v. General Tel. Co. of California*, 41 F.3d 1310, 1317 (9th Cir. 1994). Long-term disability determinations are made according to the "any occupation" standard under the Delta Plan. Thus, under *McKenzie*, it was unnecessary for the Plan to identify specific jobs within Regula's specifications in order to reject his claim.

There is ample evidence in the record to support the Administrative Committee's conclusion that Regula could perform some occupation. As the district court pointed out, "the Plan relied upon the reports of Dr. Kumar, which detailed the restrictions on Plaintiff's ability to work, and Dr. O'Brien who opined that 'there is no type of work within [Regula's] job description that he would not be able to do.' " Thus, while the Administrative Committee did not rely on vocational evidence that specifically identified potential jobs for Regula, because it was not required to do so under *McKenzie*, the evidence in the record indicates that Regula does not have an impairment that prevents him from performing "some identifiable job."

B.

Regula has asked, and the majority has agreed, to import the "treating physician rule" from Social Security disability cases for application to disability determinations under ERISA. I disagree with this holding. The treating physician rule, as applied in Social Security cases, requires that greater, though not conclusive, weight be placed on the opinion of a treating physician. *See Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989). Under the rule, specific reasons based on substantial evidence must support the rejection of a treating physician's opinion. *See Embrey v. Bowen*, 849 F.2d 418, 421 (9th Cir. 1988). I would reject the application of the treating physician rule in ERISA cases because there are significant differences between Social Security and ERISA that counsel against adoption of the rule in the ERISA arena.

Congress and the Social Security Administration ("SSA") have created an elaborate statutory and regulatory scheme governing Social Security disability determinations. *See* 42 U.S.C. §§ 401-433; 20 C.F.R. §§ 404.1-.2127, 416.101-.2227. For instance, the SSA has created a detailed five-step procedure to evaluate which claimants are disabled and therefore entitled to Disability Insurance benefits. *See* 20 C.F.R. § 404.1520, 416.920; *see also Cleveland v. Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 804 (1999) (describing the SSA's fivestep evaluation process). As part of this sequential procedure, the SSA has created grids to provide guidance about whether a claimant is disabled. *See* 20 C.F.R. § 404, Subpart P, Appendix 1-2; *Reddick v. Chater*, 157 F.3d 715, 729 (9th Cir. 1998). The SSA has also codified the treating physician rule in the regulations governing disability determinations. *See* 20 C.F.R. §§ 404.1527(d);

416.927(d). Thus, although this Court reviews Social Security benefits eligibility determinations made by an Administrative Law Judge ("ALJ") for substantial evidence and application of the correct legal standards (similar to the ERISA context), *see Flaten v. Sec'y of Health & Human Servs.*, 44 F.3d 1453, 1457 (9th Cir. 1995), an ALJ must follow far stricter guidelines (such as detailed grids) than a plan administrator making the same determination under ERISA.

In contrast to Social Security, a disability determination under ERISA is subject almost entirely to the plan's language. *See Firestone*, 489 U.S. at 115 ("[T]he validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue."); *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 944 (9th Cir. 1999) (stating that an ERISA plan abuses its discretion when it deviates from the language of the plan). Whereas Social Security sets forth a very elaborate statutory and regulatory scheme, the ERISA implementing regulations only specify minimum requirements for the consideration of claims, *see* 29 C.F.R. § 2560.503-1, and do not mention whether the treating physician rule should apply under ERISA.

Because of the differences between Social Security and ERISA, the treating physician rule should not apply in ERISA cases unless the plan's language dictates such a rule. There is no such provision in this case. Accordingly, this Court should not interfere with the contractual terms agreed upon by an employee and employer in forming an ERISA plan. In addition, neither Congress nor the Department of Labor have seen fit to include the treating physician rule within the statutory or regulatory scheme governing ERISA. Thus, unless there is a provision in an ERISA plan that calls for the application of the treating physician rule, we should decline to adopt

such a rule as part of the federal common law. This result is consistent with the general view that ERISA should be governed primarily by the language of the plan, and not by an elaborate statutory and regulatory scheme such as that governing Social Security.

As an illustration of the emphasis placed on the language of an ERISA plan, this Court has previously rejected the need for vocational evidence when a plan's language subjects the claimant's eligibility for disability benefits to the "any occupation" standard. *See McKenzie*, 41 F.3d at 1317. The vocational evidence requirement originates from the regulations governing Social Security disability determinations. *See* 42 U.S.C. § 423(d)(2)(A); 20 C.F.R. §§ 404.1520(f), 416.920(f). Under step five of the SSA's sequential evaluation procedure, the ALJ bears the burden to show that there are jobs that the claimant can perform (*i.e.* it requires consideration of vocational evidence). *See Smolen v. Chater*, 80 F.3d 1273, 1291 (9th Cir. 1996). However, under almost identical circumstances, this Court rejected the importation of the vocational evidence rule into ERISA cases when the plain language of the plan does not require the consideration of such evidence. *See McKenzie*, 41 F.3d at 1317. Thus, this Court's rule that vocational evidence is unnecessary in ERISA cases, even though it is required in Social Security cases, supports the conclusion that this Court should not read extraneous terms into an ERISA plan.

This result is also consistent with the broad discretion conferred on plan administrators under *Firestone*. The Supreme Court stated in *Firestone* that a plan granting an administrator broad discretion over eligibility determinations should be accorded deference by limiting a court's review of those decisions to an abuse of discretion standard. *See Firestone*, 489 U.S. at 115. A rule that

requires plan administrators to consider certain types of evidence and to weigh that evidence in a compulsory manner would effectively undermine that discretion. *See Dowden v. Blue Cross & Blue Shield of Texas, Inc.*, 126 F.3d 641, 644 (5th Cir. 1997) (recognizing that in determining medical necessity under an ERISA plan, granting "conclusive weight to the opinion of the attending physician would vitiate the discretionary authority expressly granted to [the plan] in the contract."). A plan administrator should be entitled to the same deference it receives on other decisions when it considers how much emphasis to place on the opinion of a treating physician.

Of the four other Circuits that have considered whether the treating physician rule should apply in ERISA cases, three have rejected the rule's application under ERISA. *See Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994) (rejecting the treating physician rule when an ERISA plan is making a determination about the medical necessity of a prescribed treatment); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (stating in dicta that the court has "considerable doubt about holding the [treating physician rule] applicable in ERISA cases."); *Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1139-40 (11th Cir. 1989) (stating that even a plan's failure to contact a treating physician is not an abuse of discretion). In a recent case, the Fourth Circuit suggested that the treating physician rule is not only inapplicable when determining medical necessity in accordance with *Sheppard*, but that it was not persuaded to apply it to disability determinations either. *See Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607 (4th Cir. 1999). Furthermore, although the fourth case, *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996), appears to support the majority's application of the treat-

ing physician rule in ERISA cases, subsequent Eighth Circuit case law has drastically undercut its precedential effect. *See Delta Family-Care Disability and Survivorship Plan v. Marshall*, Nos. 00-3441 & 00-3923, 2001 WL 856270, at *6 (8th Cir. July 31, 2001) (stating that although a reviewing physician's opinion is generally accorded less deference than that of a treating physician in reviewing disability cases under ERISA, "a treating physician's opinion does 'not automatically control, since the record must be evaluated as a whole.' "); *Fletcher-Merrit v. Noram Energy Corp.*, 250 F.3d 1174, 1180 n.3 (8th Cir. 2001). Both cases emphasize the extreme circumstances at play in *Donaho* in which two treating physicians and an examining physician contradicted the reviewing physician's conclusions. *See Delta Family-Care*, 2001 WL 856270 at *6; *Fletcher-Merrit*, 250 F.3d at 1180 n.3.

Of particular note, *Jett* and *Salley* recognize that the treating physician rule creates an inherent conflict of interest that encourages treating physicians to continue to treat their patients as disabled. *See Salley*, 966 F.2d at 1016; *Jett*, 890 F.2d at 1140. An illegitimate conflict exists in ERISA cases because "the treating physician would stand to profit greatly if the court were to find benefits should not be terminated." *Salley*, 966 F.2d at 1016. Because an ERISA plan ordinarily requires a claimant to reprove their disability periodically, a disability finding by a treating physician almost guarantees another visit by that claimant. Thus, the rule creates an inherent conflict of interest in the ERISA context that justifies a decision not to place special weight on the opinion of a treating physician. These out-of-circuit cases and their respective rationales provide further support for the conclusion that the treating physician rule should not apply to ERISA cases.

C.

Regula argues that the district court's decision to deny summary judgment was erroneous because the Plan abused its discretion as a matter of law. Specifically, Regula asserts that the Plan was required to make a finding that Regula's condition had improved before terminating his benefits. However, the plan states that a beneficiary is entitled to benefits "so long as he remains disabled." Therefore, according to the plain language of the plan, a determination that Regula was no longer disabled would justify a termination of his benefits. The Plan did not abuse its discretion in terminating his benefits because the Plan's finding that Regula was no longer disabled is supported by substantial evidence in the record and was based on a reasonable interpretation of the plan's terms. *See Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302, 1307 (9th Cir. 1986).

For Regula to prevail on appeal, he must show that the Plan abused its discretion when it denied his benefits."It is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Atwood*, 45 F.3d 1323-24. This Court should affirm the plan administrator's decision if it was based upon substantial evidence and complied with the terms of the plan. *See, e.g., Meditrust Fin. Servs. Corp. v. The Sterling Chemicals, Inc.*, 168 F.3d 211, 215 (5th Cir. 1999); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997). Substantial evidence does not mean that the plan administrator's decision must be proven correct by a preponderance of the evidence. Rather, substantial evidence "is such relevant evidence as reasonable minds

might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence." *Gilbrook v. City of Westminster*, 177 F.3d 839, 856 (9th Cir. 1999).

The Plan relied on the detailed reports of Drs. O'Brien and Kumar, who were hired by the Plan to independently assess whether Regula was still disabled. Dr. Kumar opined in a detailed eight-page report that Regula "is definitely [physically] capable of gainful employment performing some type of work." Furthermore, Kumar's report specified Regula's physical limitations and consequently concluded that he could work based on those specifications.

In contrast, most of Regula's evidence was superannuated by the time the Plan terminated his benefits. With the exception of the report by Dr. Dean Cummings, all of Regula's evidence was submitted prior to March 3, 1993, approximately two years prior to the termination of his benefits. Although Cummings' report clearly states that Regula was still permanently disabled on December 5, 1994, it was not an abuse of discretion, as a matter of law, for the Plan to reject his opinion and accept Kumar's more recent report.

Regula also argues that it was an abuse of discretion for the Plan to ignore the report submitted by his treating physician, Dr. Smith, stating that Regula's combined physical and psychological symptoms rendered him permanently disabled. This argument is without merit for two reasons. First, the Plan relied on an independent opinion submitted by Dr. O'Brien, in which he found that "Mr. Regula can return to work immediately and that there is no type of work within his job description that he would not be able to do." O'Brien's report further stated that Regula was a "malingerer" who was "consciously exaggerating his psychological and ortho-

pedic difficulties." Second, it was reasonable for the Plan to conclude that Smith's reports were less probative due to the perceived inconsistencies in her report and O'Brien's opinion that Smith might have been biased. In fact, the letter sent to Regula explaining the Administrative Committee's decision indicates that it found O'Brien's opinion more persuasive and expressed concerns about Smith's lack of objectivity based on comments she made outside of her field of expertise.

Because the Plan's decision is supported by substantial evidence, is consistent with the language of the plan, and there is no showing of clearly erroneous findings of fact, I believe that the district court correctly concluded that the Plan did not abuse its discretion as a matter of law.

III.

I also believe that the district court did not err when it found that the Plan had met the requirements of "full and fair review." Regula alleges that the Plan failed to fully comply with several technical notice requirements set forth in the regulations governing ERISA. *See* 29 C.F.R. § 2560.503-1(f). In particular, Regula contends that the Plan failed to include the following requisite information in its denial letter: (1) a specific reason for the denial; (2) a specific plan provision supporting the denial; and (3) specificity regarding how Regula could perfect his claim. The Plan did provide Regula with a "full and fair review" of his claim, however, because it substantially complied with ERISA's notice requirements. *See Terry v. Bayer Corp.*, 145 F.3d 28, 38-39 (1st Cir. 1998); *Dade v. Sherwin-Williams Co.*, 128 F.3d 1135, 1141 (7th Cir. 1997).

ERISA requires that employers must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133. The Department of Labor has further specified that adequate notice requires that the plan give a specific reason for its denial, refer to a specific plan provision on which its denial is based, provide information about how the claimant can perfect his claim, and inform the claimant about how to submit his claim for further review. *See* 29 C.F.R. § 2560.503-1(f). These notice requirements are designed to provide "a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Boyd v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Adequate notice is required to allow beneficiaries to adequately prepare for further administrative review, as well as for an appeal in federal court. *See Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 394 (5th Cir. 1998). Thus, the underlying question is whether the Plan's initial denial letter afforded Regula the necessary notice allowing him to seek further review of his claim. *See Dade*, 128 F.3d at 1142.

The Plan's letter referred to the relevant plan provisions and provided specific reasons for the denial. The letter indicated that the Plan exclusively relied upon the independent medical reports submitted by Drs. Kumar and O'Brien in denying his claim. The letter specifically informed Regula that both doctors concluded that he was "able to do some type of work," justifying the Plan's conclusion that Regula was no longer disabled. In addition, the letter also referenced the specific provision in the plan that supported the denial—the letter explained that Regula's condition no longer met the definition of long-term disability found in Section 4.03 of the plan.

Where, as here, a denial letter cites to a specific plan provision and the relevant physician reports support the denial, a plan has met the notice requirements of § 2560.503(f)(1)-(2). *See Collins v. Cent. States, Southeast and Southwest Areas Health and Welfare Fund*, 18 F.3d 556, 561 (8th Cir. 1994).

The Plan also provided Regula with the necessary information to perfect his claim. *See* 29 C.F.R. § 2560.503-1(f)(3). In its denial letter, the Plan notified Regula that in order to perfect his claim, he "must establish by objective evidence that [he is] continuously and totally disabled from engaging in any occupation or work for compensation or profit." In many situations, a plan is uncertain about what types of additional evidence might perfect a claim. For example, in *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1091 (9th Cir. 1998) (en banc), this Court recognized that there are situations when a plan does not need to inform a claimant about how to perfect his claim because additional evidence would not change the outcome. Regula did, in fact, submit additional objective evidence, which the Plan found unpersuasive. The notice provided by the Plan and the Plan's request for "additional objective evidence" substantially complied with the ERISA notice requirements.

Regula also argues that the denial letter sent by the Administrative Subcommittee after his first appeal did not contain instructions regarding how he could perfect his appeal. However, it is unnecessary for a denial letter following an appeal to provide information about how a claimant can perfect his claim. *See* 29 C.F.R. § 2560.503-1(h)(3).

He further contends that a letter sent by the Plan that purportedly cured any defects in the earlier denial letter arrived only six days prior to his final appeal to the Administrative Committee, thereby arriving too late to

be of any assistance. However, this contention has no merit because the earlier letter did meet the notice requirements, rendering consideration of that final letter unnecessary.

Regula's final contention on appeal is that the Plan failed to provide him with a full and fair review because it did not afford him sufficient time to comment on and review pertinent documents prior to his final appeal to the Administrative Committee. Under 29 C.F.R. § 2560.503-1(g)(1), an ERISA plan must allow a claimant to "[r]eview pertinent documents" and "[s]ubmit issues and comments in writing." *Id.* This requirement means that a benefit plan must "provide claimants with access to 'the evidence the decisionmaker relied upon' in denying their claim." *Wilczynski v. Lumbermens Mutual Cas. Co.*, 93 F.3d 397, 402 (7th Cir. 1996). A benefit plan does not need to allow a claimant to review every document in his administrative file, but only those documents that are influential in the plan's decision. *See id.* By Regula's own admission, his attorney was able to review and comment upon the reports provided by Drs. Kumar and O'Brien, which the Plan relied on exclusively in denying Regula's claim. Therefore, although Regula may not have inspected all the information in his administrative file, he was able to examine and comment upon all the information that formed the basis for the denial of his claim.

The Plan did not deny Regula a full and fair review of his claim because the Plan substantially complied with the procedural requirements found in ERISA's implementing regulations. *See* 29 C.F.R. § 2560.503-1.

IV.

For these reasons, I respectfully dissent. The judgment of the district court should be affirmed.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No. CV 96-7304 RSWL(VAPx)
Filed February 17, 1998

FRANK REGULA,

Plaintiff,

—v.—

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

Defendant.

ORDER DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I.

INTRODUCTION

This action arises out of Plaintiff Frank Regula's ("Plaintiff") claim that Defendant Delta Family-Care Disability and Survivorship Plan ("the Plan") deprived him of disability benefits owed him by the Plan. Plaintiff filed this action on October 17, 1996, seeking declaratory relief and benefits under the Plan.

Plaintiff now moves for summary judgment pursuant to Federal Rule of Civil Procedure 56, on the grounds

that there is no genuine issue as to any material fact and Federal Express is entitled to judgment as a matter of law. This Motion was set for oral argument on October 20, 1997, but was removed from the Court's law and motions calendar pursuant to Federal Rule of Civil Procedure 78 for disposition based on the papers filed.

After carefully reviewing the papers submitted in support of and in opposition to the Motion, the Court hereby **DENIES** Plaintiff's Motion for Summary Judgment.

II.

BACKGROUND

The Plan is a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan provides short and long term disability benefits to employees of Delta Air Lines, Inc. ("Delta") under specified conditions.

The Plan is administered by the Plan's Administrative Committee (the "Administrative Committee"), which is granted full discretion to decide all claims for benefits and to review the appeals of benefit claims. A participating Delta employee may qualify for short term disability benefits under the Plan Documents[1] "when disabled as a result of a demonstrable injury or disease . . . which prevents [him] from engaging in [his] customary occupation." (Compl., Ex. 1 at 24.) Upon expiration of his short term disability, the employee may qualify for long term disability if he demonstrates that he is "disabled at that time as a result of demonstrable injury or disease . . . which will continuously and

[1] "Plan Documents" refers to the Document entitled "Delta Family-Care Disability and Survivorship Plan (As Amended and Restated Effective January 1, 1994)."

totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work." (Compl., Ex. 1 at 25.) Once a participant begins receiving disability benefits under the Plan, his status is regularly reviewed in order to determine whether he remains qualified to receive those benefits.

If a participant's claim for disability is denied, he is entitled to two levels of internal review. First, the participant must appeal the denial to the Plan's Administrative Subcommittee. (Compl., Ex. 1 at 42.) If the participant is not satisfied with the determination made by the Subcommittee, he may appeal the Subcommittee's determination to the Administrative Committee. (Compl., Ex. 1 at 42, 43.)

Plaintiff worked as a clerk for Delta. As an employee, Plaintiff was a participant in the Plan. On September 15, 1987, Plaintiff filed a claim for short term disability benefits, claiming that he had sustained a "cervical disc injury."[2] (A.R. DEL1000.) Based on Plaintiff's claim of injury and supporting physician statements, the Plan awarded Plaintiff short term disability benefits through October 30, 1987. On November 11, 1987, Plaintiff applied for long term disability benefits. The Plan approved long term disability benefits for Plaintiff for an initial period between October 31, 1987, and January 31, 1988. On several occasions thereafter, the Plan extended Plaintiff's long term disability benefits based upon medical reports it received from Plaintiff's treating physicians regarding Plaintiff's condition.[3]

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[2] In addition to his cervical injury, Plaintiff later developed recurrent abdominal pain, depression and anxiety.

[3] The physicians who examined Plaintiff during this period include Michael Smith, MD, H. Dale Richardson, MD, Peter Schou, PhD, Alfred Bloch, MD, PhD, Burton Wixen, MD, Sandra Smith, PhD, and Dean H. Cummings, D.C.

In a report dated August 1, 1994, Dr. Sandra Smith, one of Plaintiff's treating physicians, indicated that it was unknown whether Plaintiff would continuously be unable to work in any occupation, and that, with appropriate vocational rehabilitation services, Plaintiff might be able to engage in some part-time work in six to twelve months. (A.R. DEL1169.) Thereafter, the Plan requested additional information from Dr. Smith regarding the likelihood that Plaintiff might be able to work in six to twelve months with rehabilitation services. In response, Dr. Smith indicated that Plaintiff's "combined physical and emotional symptom complex" prevented him from enrolling in a vocational rehabilitation program. (A.R. DEL1171-73.)

In a letter dated December 22, 1994, the Plan arranged for Plaintiff to be examined by Dr. Rajeswari Kumar, an independent orthopedic medical examiner. (A.R. DEL1177-78) Dr. Kumar was asked to provide an opinion as to whether Plaintiff was able to perform some type of work and, if so, to identify what type of work he was able to perform. After examining Plaintiff, Dr. Kumar reported: "I believe the patient is definitely capable of gainful employment performing some type of work." (A.R. DEL1186.)[4] In response to Dr. Kumar's report, Dr. Smith stated that she "found Dr. Kumar's

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[4] More specifically, Dr. Kumar stated that Plaintiff is "capable of performing tasks limited to lifting 25 pounds occasionally and 15 pounds frequently. Standing and walking can be done up to four to six hours per day. His sitting tolerance is six hours per day. Pushing and pulling are limited to the same amounts as lifting. He is able to bend, squat and crawl occasionally, climb frequently and work in unprotected heights. There is no limitation reaching above the shoulder level with both upper extremities, using the feet for repetitive movements as in operating foot controls, using both hands for repetitive simple grasping, pushing and pulling and fine manipulating." (A.R DEL1186.)

description of [Plaintiff's] abilities to be absolutely inconceivable." (A.R. DEL1189.) She further noted that notwithstanding Dr. Kumar's report as to Plaintiff's physical condition, Plaintiff's psychological condition prevented him from returning to work. (A.R. DEL1188.)

Thereafter, the Plan arranged for an independent psychiatrist, Dr. James O'Brien, to examine Plaintiff in order to determine whether he was psychologically disabled within the meaning of the Plan Documents. After examining Plaintiff, Dr. O'Brien reported that Plaintiff was "consciously exaggerating his psychological and orthopedic difficulties." (A.R. DEL1207.) Dr. O'Brien further opined that "Mr. Regula can return to work immediately and that there is no type of work within his job description that he would not be able to do." (A.R. DEL1208.)

In a letter dated July 25, 1995, the Plan notified Plaintiff that it determined that he was able to work and that he therefore was no longer entitled to disability benefits. (A.R. DEL1214-15.) Accordingly, the Plan discontinued such benefits, effective July 25, 1995.

Through his attorney, Plaintiff appealed the denial of benefits on September 28, 1995, to the Administrative Subcommittee. The Subcommittee concluded that the denial of continued long term disability benefits to Plaintiff was proper. On December 6, 1995, Plaintiff appealed the Subcommittee's determination to the Plan's Administrative Committee. In a letter dated February 13, 1996, the Plan informed Plaintiff that it found that he "was not totally disabled within the meaning of the Plan." (A.R. DEL1436-38.)

Plaintiff filed the instant action on October 17, 1996, for declaratory relief and disability benefits under the Plan. Plaintiff now moves for summary judgment on both of those claims.

III.

DISCUSSION

A. Standard for Issuance of Summary Judgment

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56. The moving party bears the initial responsibility of identifying the absence of a genuine material issue of fact. *Celotex v. Catrett*, 477 U.S. 317, 323 (1986).

In opposing the motion for summary judgment, the non-moving party is required by Rule 56(e) to go beyond the pleadings and designate specific facts showing that there is a genuine issue for trial. *Celotex*, 477 U.S. at 324. Non-moving parties can meet this burden by use of affidavits, depositions, answers to interrogatories, or admissions on file. *Id.*, However, conclusory allegations unsupported by factual data are insufficient to create a triable issue of fact so as to preclude issuance of summary judgment. *Hansen v. United States*, 7 F.3d 137, 138 (9th Cir. 1993).

B. Applicable Standard of Review

It is well settled that courts must apply an "abuse of discretion" standard in reviewing a denial of benefits where the language of an ERISA-governed plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Snow v. Standard Ins, Co.*, 87 F.3d 327, 330 (9th Cir. 1996). In this case, section 12.02 of the Plan Documents provides that "[t]he Administrative Committee shall have the broadest discretionary authority permitted under law in the exercise of all its functions including,

but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder . . ." (Compl., Ex. 1 at 51.) Because the Plan Documents clearly give the Administrative Committee broad discretionary authority to determine eligibility under the Plan, and to interpret the terms of the Plan Documents, the Court must review the Administrative Committee's decision to revoke Plaintiff's long term disability benefits for an abuse of discretion.[5]

A plan administrator's interpretation of the plan and its decisions regarding benefits claims are given broad deference when reviewed by the court for an abuse of discretion. An administrator will have abused its discretion if it makes a decision "without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Snow*, 87 F.3d at 331 (*quoting Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323-24 (9th Cir. 1995)). "Review under the 'clearly erroneous' standard is significantly deferential, requiring a 'definite and firm conviction that a mistake has been committed.' " *Snow*, 87 F. 3d at 331 (*quoting Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 508 U.S. 602, 623 (1993)). Under that standard, the court must determine whether the plan administrator's interpretation of the plan is a reasonable one, not whether it is the correct one or whether it is the interpretation that the court would

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[5] Plaintiff argues that under *Jordal v. Simmons*, 926 F.2d 223, 225-26 (2d Cir. 1991), the Court must review the Administrative Committee's decision *de novo* because the Administrative Committee denied his long term disability benefits after reevaluating his status, rather than initially. There is no case law supporting Plaintiff's position, and Plaintiff's reliance on *Jordal* is entirely misplaced. Unlike the instant case, in *Jordal*, the court found that the plan trustees were not given discretion to construe the applicable plan.

have made on its own. *See Snow*, 87 F.3d at 332 ("[The 'clearly erroneous'] standard certainly does not permit the overturning of a decision where there is *substantial evidence* to support the decision, that is, where there is 'relevant evidence [that] reasonable minds might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence.") *(quoting Maynard v. City of San Jose*, 37 F.3d 1396, 1404 (9th Cir. 1994) (emphasis added)). In making that determination, the court is limited to the facts known to the administrator at the time the benefits claim decision was made. *Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1471 (9th Cir. 1993).

C. Plaintiff's Motion for Summary Judgment

Plaintiff seeks judgment reversing the decision of the Plan and granting him disability benefits. Plaintiff makes three arguments in support of his Motion for Summary Judgment. First, Plaintiff argues that the Administrative Committee erred because it refused to apply the "treating physician rule," which requires the Administrative Committee to give greater weight to the opinions of Plaintiff's treating physicians than to the opinions of the independent medical examiners concerning his disability. Second, Plaintiff argues that the Administrative Committee's decision that he was no longer eligible for long term disability benefits was an abuse of discretion because it was not supported by substantial evidence. Third, Plaintiff argues that the Plan abused its discretion by concluding that Plaintiff could perform some type of work since that determination was not supported by vocational evidence.

Finally, Plaintiff argues that, in the alternative to granting summary judgment in his favor, the Court should, at a minimum, remand this matter for further

proceedings under the Plan because the Administrative Committee failed to provide him with the opportunity for a full and fair review.

1. *The Treating Physician Rule Does Not Apply In ERISA Actions*

Plaintiff argues that in determining whether he was permanently disabled under the Plan, the Administrative Committee should have applied the "treating physician rule." Under the "treating physician rule," a treating physician's opinion may be disregarded only where there are specific, legitimate reasons for doing so that are based on substantial evidence in the record. *Murray v. Heckler*, 722 F.2d 499, 501-2 (9th Cir. 1983). Although the "treating physician rule" is regularly applied in social security cases, and has also been applied in workers' compensation and Federal Tort Claims Act cases, the law is unsettled as to whether the rule applies in cases governed by ERISA. Indeed, the Ninth Circuit has never addressed the propriety of applying the treating physician rule in ERISA cases.

A requirement that a plan administrator must apply the "treating physician rule" is fundamentally inconsistent with the wide discretion granted to plan administrators in deciding claims for benefits under ERISA-governed welfare benefit plans. As discussed above, under ERISA, it the responsibility of a plan administrator to evaluate the evidence before him and to make an eligibility determination. The Court reviews that determination for an abuse of discretion, i.e., to determine whether it was made "without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Snow*, 87 F.3d at 331 (*quoting Atwood*, 45 F.3d at 1323-24. A requirement that the plan administrator must apply the "treating

physician rule" would require that the administrator weigh the facts in a particular fashion. This is inconsistent with the very deferential standard applied by the court in reviewing the administrator's decision.

Furthermore, as stated by the Fifth Circuit:

> We have considerable doubt about holding the rule applicable in ERISA cases. Under it, the treating physician would stand to profit greatly if the court were to find benefits should not be terminated. There is a clear and strong conflict of interest, and we are doubtful that a court should defer automatically to his or her testimony.

Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1016 (5th Cir. 1992); *See also Jett v. Blue Cross and Blue Shield of Alabama*, 890 F.2d 1137, 1140 (11th Cir. 1989) ("The Social Security law that greater weight must be given to the opinion of the treating physician is not applicable to the decision of the claims administrator of an ERISA-governed employee health plan where the treating physician has an economic interest in the matter.")

Because the plan administrator has wide discretion in making eligibility determinations, that determination encompasses his decision as to whether the treating physicians' reports are entitled to greater weight than those of the non-treating physicians. Thus, if the administrator decides that, for some reason, the reports of the non-treating physicians are entitled to greater weight than the reports of the treating physicians, that determination may be overturned only if the court finds that the plan administrator abused his discretion in making such determination.

In this case, the Plan considered and rejected Plaintiff's argument that it should "give deference to the treating physician over that of other physicians":

> While the Committee agrees that in many cases the treating physician may know the most about an employee's condition, the Committee believes that there are many times when an independent or objective evaluation can be more valuable and insightful.

(A.R. DEL1438.)

Because it is within the discretion of the Administrative Committee to determine the weight to be given to the evidence presented with respect to Plaintiff's claim for benefits, the Court finds that the Administrative Committee did not abuse its discretion by refusing to apply the "treating physician rule" in making its determination as to Plaintiff's eligibility for long-term disability benefits.[6]

2. *The Administrative Committee's Decision Was Not, As A Matter Of Law, An Abuse Of Discretion*

Plaintiff argues that the Administrative Committee's decision that he was no longer eligible for long-term disability benefits was an abuse of discretion because it was

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[6] Courts deciding ERISA claims have routinely approved of plan administrators' use of non-treating and/or non-examining physicians' opinions in making eligibility determinations. *See, e.g., Sweatman v. Commercial Union Ins, Co.*, 39 F.3d 594, 601-02 (5th Cir. 1994) (finding no abuse of discretion where administrator relied on opinions of non-treating, independent doctors in determining the plaintiff's eligibility for benefits); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir., 1994) (upholding plan administrator's denial of benefits where decision was based on a permissible choice between independent, non-examining medical consultants and plaintiff's physicians).

not supported by substantial evidence. It should be noted that "substantial evidence" does not mean a preponderance of the evidence. Rather, "substantial evidence" means " 'relevant evidence [that] reasonable minds might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence.' " *Snow*, 87 F.3d at 332 (*quoting Maynard*, 37 F.3d at 1404. After reviewing the administrative record in its entirety, the court simply cannot find that, as a matter of law, the Administrative Committee's determination was not based upon "substantial evidence," i.e., that it was an abuse of discretion. *Id.*

The administrative record is not, as Plaintiff claims, entirely supportive of his claim that he is totally and permanently disabled. (*See*, *e.g.*, A.R. DEL1087, DEL1088, DEL1089, DEL1162, DEL1169.)[7] Furthermore, the independent medical examiners' opinions support the Administrative Committee's determination as to Plaintiff's orthopedic and psychological disabilities. (A.R. DEL1180-87, DEL1196-213.) Those opinions were rendered after reviewing Plaintiff's medical file and examining Plaintiff himself. They therefore cannot be said to be "clearly erroneous findings." Finally, because Plaintiff's treating physician Dr. Smith's reports are somewhat inconsistent (*see* A.R. DEL1169, DEL1171-73),

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[7] The Court rejects Plaintiff's argument that, as a matter of law, the Plan failed to demonstrate that Plaintiff did not "remain disabled" as required by the Plan. Plaintiff specifically claims that the Plan must demonstrate that Plaintiff's condition "improved" since the time that the Plan determined that he was disabled. Even assuming that the Plan must make such a showing, the independent medical examiners' opinions, which cannot be said as a matter of law to be "clearly erroneous findings," supported the Administrative Committee's determination. Thus, the Court cannot find, as a matter of law, that the Administrative Committee's determination was an abuse of discretion.

and because the independent examiners' detailed reports were prepared after reviewing Plaintiff's medical file and conducting examinations of Plaintiff himself, the Court cannot find that, as a matter of law, the Administrative Committee's decision to rely upon the independent examiners' opinions was an abuse of discretion.

3. *The Plan Was Not Required To Obtain Vocational Evidence To Make Its Determination As To Plaintiff's Qualification For Long-Term Benefits*

Plaintiff argues that the Plan abused its discretion by concluding that he could perform "some type of work" because that conclusion was not supported by vocational evidence. However, the Ninth Circuit has specifically rejected the notion that vocational evidence is necessary in all situations:

> In accord with the Fifth Circuit and the District of Columbia Circuit, we hold that consideration of vocational evidence is unnecessary where the evidence in the administrative record supports the conclusion that the claimant does not have an impairment which would prevent him from performing some identifiable job. The plan administrator is not required in every case where the 'any occupation' standard is applicable to collect vocational evidence in order to prove there are available occupations for the claimant.

McKenzie v. General Telephone Co. of Cal., 41 F.3d 1310, 1317 (9th Cir. 1994), *cert. denied*, 514 U.S. 1066 (1995).

In this case, the Administrative Committee was not necessarily required to obtain vocational evidence to

support its determination that Plaintiff is not disabled because, as discussed above, the administrative record does not fail to support the Administrative Committee's determination as a matter of law. Furthermore, Plaintiff's argument that the Administrative Committee must identify a particular job which Plaintiff can perform is unsupported by case law. The Ninth Circuit has stated that an administrative committee must demonstrate that the participant can perform "some identifiable job," not "an identified job." *Id.* In this case, as noted above, the Plan relied upon the reports of Dr. Kumar, which details the restrictions on Plaintiff's ability to work (A.R. DEL1186), and Dr. O'Brien who opined that "there is no type of work within [Plaintiff's] job description that he would not be able to do." (A.R. DEL1208.) It clearly cannot be said that, as a matter of law, this is insufficient to support the Administrative Committee's determination that Plaintiff could perform "some type of work." *See McKenzie*, 41 F.3d at 1317-18.

The Court simply cannot find that the Administrative Committee's failure to obtain vocational evidence was an abuse of discretion as a matter of law.

4. *Plaintiff Was Not Denied A Full And Fair Review of His Claim For Benefits*

Plaintiff argues that, in making the final determination as to Plaintiff's eligibility for long-term disability benefits, the Plan failed to provide him with an opportunity for a full and fair review.

> An ERISA plan "shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant: (1) The specific reason or reasons for the denial; (2) Specific reference to per-

> tinent plan provisions on which the denial is based; (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review."

Booton v. Lockheed Medical Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997) (quoting 29 C.F.R. § 2560.503-1(f)). "In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Id.*

In this case, Plaintiff was not denied the opportunity for a full and fair review of the denial of his claim for benefits. The initial denial of benefits to Plaintiff (A.R. DEL1346-47), the denial of Plaintiff's appeal to the Administrative Subcommittee (DEL1357-58, DEL1359-60), and the denial of Plaintiff's appeal to the Administrative Committee (A.R. DEL1436-38) specify in detail the documents reviewed and the basis for the decision. Furthermore, the Plan clearly advised Plaintiff of the steps to be taken in the event that Plaintiff wished to submit his claim for review (*see* A.R. DEL1346-47, DEL1359-60), and any additional information that would assist Plaintiff to perfect his claim. (*See* A.R. DEL1346-47, DEL1422-23.) Thus, the Court finds that Plaintiff was not denied a full and fair review of his claim, and the Court shall not remand this matter for further proceedings under the Plan.

IV.

CONCLUSION

Plaintiff's Motion for Summary Judgment is **DENIED.** The Court finds that the "treating physician rule" does not apply to ERISA cases and that the Administrative Committee's decision that Plaintiff was no longer eligible for long term disability benefits was not, as a matter of law, an abuse of discretion. Finally, Because Plaintiff was not denied the opportunity for a full and fair review, the Court shall not remand this matter for further proceedings under the Plan.

In opposition to Plaintiff's Motion for Summary Judgment, the Plan argues that, not only should the Court deny Plaintiff's Motion, but the Court should also grant summary judgment in favor of the Plan, *sua sponte*. The Court, however, will not address the merits the Plan's argument that it is entitled to judgment in its favor absent a properly noticed motion.

Thus, the Court hereby sets the pre-trial conference in this matter for April 20, 1998, at 11:00 a.m., and a two-day court trial for May 12, 1998, at 9:00 a.m.

IT IS SO ORDERED.

/s/ RONALD S.W. LEW
RONALD S.W. LEW
United States District Judge

DATED: February 17, 1997

No. CV-96-7304-RSWL; *Regula v. Delta Family-Care Disability & Survivorship Plan*; Plaintiff's Motion for Summary Judgment (Regulasj.ord.o)

I HEREBY CERTIFY THAT THIS DOCUMENT WAS SERVED BY FIRST CLASS MAIL, POSTAGE PREPAID, TO ALL COUNSEL (OR PARTIES) AT THEIR RESPECTIVE MOST RECENT ADDRESSES OF RECORD IN THIS ACTION ON THIS DATE.

DATED: 2/18/98
HELENA G. [ILLEGIBLE]
DEPUTY CLERK

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No.: CV 96-7304 RSWL(VAPx)
Filed March 25, 1998

FRANK REGULA,

Plaintiff,

—VS.—

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

Defendant.

STIPULATION FOR THE ENTRY OF JUDGMENT; AND ORDER

TO THE HONORABLE RONALD S. W. LEW, JUDGE OF THE DISTRICT COURT:

Whereas plaintiff Frank Regula filed a motion for summary judgment in the above-captioned matter on August 11, 1997, which defendant Delta Family-Care Disability and Survivorship Plan opposed;

Whereas the court has issued an order denying plaintiff's motion for summary judgment;

Whereas the issues at trial are identical to those issues set forth in plaintiff's motion for summary judgment and defendant's opposition thereto;

Whereas of the facts before the court at trial are limited to the record before the plan administrator of defendant, consisting of the record before the court on the motion for summary judgment; and

Whereas the parties wish to preserve scarce resources;

THE PARTIES HEREBY STIPULATE AND AGREE AS FOLLOWS:

If the "treating physician rule" does not apply to ERISA cases, and if the Administrative Committee's decision that plaintiff was no longer entitled to long term disability benefits was not, as a matter of law, an abuse of discretion, and if plaintiff was not denied an opportunity for full and fair review, then plaintiff cannot prevail at trial and defendant is entitled to judgment.

Plaintiff Frank Regula has preserved his rights to appeal on his contentions raised in his motion for summary judgment. The court has necessarily rejected as a matter of law each of the points raised.

Based upon the decision of the District Court, defendant is entitled to judgment.

IT IS SO STIPULATED.

DATE: March 13, 1998

Respectfully submitted,

LAW OFFICES OF LAWRENCE D. ROHLFING

By: LAWRENCE D. ROHLFING
Lawrence D. Rohlfing
Attorney for plaintiff FRANK REGULA

DATE: March 24, 1998

MUNGER, TOLLES & OLSON, LLP

By: [ILLEGIBLE]
D. Barclay Edmundson
Attorneys for defendant DELTA FAMILY-CARE AND SURVIVORSHIP PLAN

ORDER

IT IS SO ORDERED.

DATE: March 25, 1998

RONALD S.W. LEW
THE HONORABLE RONALD S.W. LEW
JUDGE OF THE DISTRICT COURT

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 98-55853
D.C. No. CV-96-07304-RSWL
Filed March 15, 2002

FRANK REGULA,

Plaintiff-Appellant,

—v.—

DELTA FAMILY-CARE DISABILITY
SURVIVORSHIP PLAN,

Defendant-Appellee.

Before: B. FLETCHER, D.W. NELSON, and BRUNETTI,
Circuit Judges

ORDER

A majority of the panel has voted to deny the petition for rehearing. Judges B. Fletcher and D.W. Nelson recommended denying the petition for rehearing en banc and Judge Brunetti recommended in favor of rehearing en banc.

The full court was advised of the petition for rehearing en banc. An active judge requested a vote on whether

to rehear the matter en banc. The matter failed to receive a majority of the votes of the non-recused active judges in favor of en banc consideration. Fed. R. App. P. 35.

The petition for rehearing is denied and the petition for rehearing en banc is rejected.

29 U.S.C. § 1132. Civil Enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 C.F.R. § 2560.503-1 Claims procedure.

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time

frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify

that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees)—

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference—

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) Group health plans. The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

(1)(i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that—

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those

permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit

determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) Plans providing disability benefits. The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) Timing of notification of benefit determination. (1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan admin-

istrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the Plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's ben-

efit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent care decisions. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments—

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall

be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) Other claims. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable

period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the

circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) Calculating time periods. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant —

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations. (1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically

necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) Timing of notification of benefit determination on review. (1) In general. (i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such

as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides

for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) Post-service claims. (A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for

review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) Disability claims. (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for

review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) Calculating time periods. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on

which the claimant responds to the request for additional information.

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(k) Preemption of State law. (1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2)(i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review

procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(l) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1)(i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the

claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i) of this section shall be treated as a "claim involving urgent care" for purposes of this section.

(2) The term "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term "post-service claim" means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or

make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term "group health plan" means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

(7) The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph

(b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) Apprenticeship plans. This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) Applicability dates. This section shall apply to claims filed under a plan on or after January 1, 2002.

[65 FR 70265, Nov. 21, 2000]

20 C.F.R. § 404.1527(d) Evaluating opinion evidence.

(d) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend

on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see Secs. 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

SELECTED PROVISIONS OF THE DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN

SECTION FOUR

DISABILITY BENEFITS

4.01 *Eligibility for Disability*: An Employee shall be eligible for Short-Term Disability Benefits under Section 4.02 of the Plan only if such disability commences while the Employee is eligible under Sections 2.01 (a) or 2.02. An Eligible Employee shall be eligible for Long-Term Disability Benefits under 4.02 only if such disability commences while the Employee is eligible under Sections 2.01 (b) or 2.02; provided, however, an Employee shall not be eligible for Long Term Disability Benefits for any disability commencing after age 65. An Employee who is eligible for either Short-Term or Long-Term Disability Benefits under the Plan shall be eligible for such benefits only so long as he is under the care of a physician or surgeon for the injury or disease or pregnancy which is the disabling condition and meets the other requirements of the Plan.

* * *

4.03 *Long Term Disability*: If upon expiration of the Employee's Short Term Disability period, he continues to qualify for Short Term Disability, the Employee may apply for Long Term Disability. The Employee shall be eligible for Long Term Disability provided he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work. During the period an

Employee qualifies for Long Term Disability, he will be eligible to receive monthly income benefits in an amount determined under Section 7.02. The Employee shall be eligible for Long Term Disability benefits so long as he remains disabled in accordance with this subsection and Section 4.01.

* * *

4.05 *Determination of Disability*: Disability as herein defined in Sections 4.02 and 4.03 shall be determined by the Administrative Committee or its designees in their sole discretion. The Committee or its designees may request a medical examination of the Employee by a physician or physicians appointed on behalf of the Committee before determining disability and during the disability period to determine if the Employee remains disabled. Failure to cooperate with requests for medical examination made on behalf of the Committee shall be grounds for denying disability benefits hereunder.

SECTION ELEVEN

CONTRIBUTIONS AND BENEFIT FUND

11.01 *Employee Contributions*: No contributions shall be required from an Employee, except that an Employee on approved leave of absence, as described in Section 2.01(d)(vii), and Temporary Employees described in Section 2.01(d)(iv) must contribute to be eligible for or to continue coverage for Basic Life Benefits hereunder. The amount of contribution required shall be determined by the Administrative Committee from time to time on a uniform basis with respect to all persons similarly situated. Such contributions must be paid monthly in advance and will be used to provide benefits under the Plan.

11.02 *Contributions By The Employing Companies*: The Plan shall engage an Actuary to submit annually an actuarial valuation evidencing the actuarial position and actuarial costs of the Plan. Each such actuarial statement or actuarial valuation shall give regard to the Plan's short-term and long-term financial needs, including liquidity requirements, and shall be forwarded to the person or persons in the Employing Company designated by the Administrative Committee to review such statements and valuations and to recommend appropriate contributions to the Benefit Fund by the Employing Companies. The contributions of the Employing Companies shall be paid at reasonable periodic intervals taking into consideration the recommendations contained in the latest actuarial valuation.

11.03 *Benefit Fund*: The Company shall establish and maintain a Benefit Fund into which the contributions of each Employing Company under this Plan shall be paid and all benefits will be paid exclusively from the Benefit Fund. The Benefit Fund may comprise any combination of trust funds and insurance contracts. The Benefit Fund shall be allocated among Employing Companies under the direction of the Administrative Committee. Where an Employee transfers from one Employing Company to another he shall be treated to the extent practical and consistent with his accumulated credits as having always been with the new Employing Company for the purpose of allocated assets and liabilities.

11.04 *Exclusive Benefit Rule*: At no time shall any part of the corpus or income of the Benefit Fund be used for or diverted to any purpose other than for the exclusive benefit of the Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan. No person, including the Employing Companies,

shall have any financial interest in or right to the Benefit Fund or part thereof, except as expressly provided for in the Plan and the Trust.

11.05 *Source of Benefit Payments*: Benefit payments shall be paid directly to the Participant or Beneficiary from the Benefit Fund including any insurance policies entered into by the Plan. Such payments shall be made upon the written order of the Administrative Committee or its delegate. Resources for benefit payments are limited to the Benefit Fund and any insurance policies owned by the Benefit Fund.

11.06 *Forfeitures and Investment Income*: Forfeitures and investment income shall be used to reduce Company contributions and shall not be used hereunder to increase the benefit of any person prior to termination of the Plan or complete discontinuance of contributions.

SECTION TWELVE

ADMINISTRATION

12.01 *Administrative Committee*: The operation and administration of the Plan (except the responsibility for investment and control of assets, which is given to the Benefit Funds Investment Committee pursuant to Section 12.07 of this Plan), the exclusive power to interpret it, and the responsibility for carrying out its provisions are vested in the Administrative Committee of at least three members, which Committee shall be the Administrator of the Plan, provided, however, that this responsibility shall not extend to the management and control of the assets of the Plan. The Board of Directors of the Company shall appoint the Administrative Committee members and their alternates and shall have the power of removal and substitution, and shall designate the Chairman of the Com-

mittee. Any Administrative Committee member may resign by notifying the Company and the Administrative Committee Secretary in writing. The Administrative Committee shall establish rules for administration of the Plan and transaction of its business. The Administrative Committee shall be the named fiduciary of the Plan for purposes of operation and administration of the Plan, and, in addition, any duty which is not expressly allocated to the Benefit Funds Investment Committee, or with respect to which an allocation is in doubt, shall be deemed to be allocated to the Administrative Committee.

12.02 *Powers and Duties of the Administrative Committee*: In addition to powers and duties otherwise stated in this Plan, the Administrative Committee shall have such duties and powers as may be necessary to discharge its responsibilities under the Plan, including, but not limited to, the following:

(a) To establish and enforce such rules, regulations, and procedures as it shall deem necessary or proper for the efficient operation and administration of the Plan;

(b) The discretionary authority to interpret and construe the Plan, and decide all questions of eligibility of any Eligible Family Member to participate in the Plan or to receive benefits under it, its interpretation and decisions to be final and conclusive.

(c) To determine the amount, manner, and time of payment of benefits which shall be payable to any Employee or Dependent, in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits shall be paid;

(d) To authorize the payment of benefits and reasonable expenses for administering the Plan;

(e) To prescribe procedures to be followed in filing applications for benefits;

(f) To prepare and distribute, in such manner as the Administrative Committee determines to be appropriate and consistent with applicable law, information explaining the Plan;

(g) To decide all questions concerning the Plan;

(h) To furnish the Board of Directors of the Company, upon request, and government agencies as required, such reports with respect to the administration of the Plan as are reasonable and appropriate, and

(i) To delegate its power and duties as set forth in Section 12.04.

The Administrative Committee shall have the broadest discretionary authority permitted under law in the exercise of all its functions including, but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder but shall act in an impartial and non-discriminatory manner with respect thereto.

12.03 *Administrative Committee Actions*: The decisions of the Administrative Committee as to interpretation and application of the Plan shall be final. A certification of acts and directives of the Committee by the Secretary of the Administrative Committee shall constitute complete proof to third parties dealing with the Administrative Committee of the authenticity of such acts and directives.

[LETTERHEAD OF DELTA AIR LINES]
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February 13, 1996

Lawrence Rohlfing, Esq.
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Santa Fe Springs, CA 90670

Re: Frank Regula

At its February 13 meeting, the Administrative Committee considered your client's appeal regarding the denial of long term disability benefits. To receive benefits, Section 4.03 of the Plan requires that "an employee shall be eligible for long-term disability provided he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work." In reviewing the claim, the Committee considered all of the information in your client's file, including all of your arguments in support of the claim.

The Committee noted the large amount of medical information in this file dating back for several years. Initially the Committee noted that there were several inconsistent reports regarding Mr. Regula's condition, particularly amongst the doctors who have examined him

for his workers' compensation benefits. While some of the medical reports indicated that Mr. Regula is totally disabled, other reports stated that he was only disabled from overhead lifting and other strenuous activity. (See the May 25, 1989 report of Dr. Michael Smith and the January 1991 report of Dr. Alban. Additionally, see the report of Dr. Wixen who disagreed with Dr. Bloch as to the extent of Mr. Regula's difficulties.) In light of the conflicting information, the Committee noted that the Plan had ordered two independent medical examinations. The medical IME, Dr. Kumar, after performing an examination and review of the pertinent medical records, stated that Mr. Regula is "definitely capable" of working. The psychiatric IME, Dr. O'Brien, provided a strong opinion that he believed Mr. Regula to be malingering and that there was no cognitive impairment. Dr. O'Brien also stated that he does not lightly or quickly suggest that an individual is malingering. The Committee also noted Dr. O'Brien's criticism of Dr. Smith's opinions, and Dr. O'Brien's statement that Mr. Regula's failure to consider prescription drug therapy is "ridiculous."

In support of the claim, the Committee reviewed all of the recent reports from Dr. Shapero, Dr. Smith and the chiropractor, Dean Cummings, in addition to all of the prior reports from Dr. Michael Smith, Dr. Bloch and the other physicians. The Committee noted that Dr. Shapero was treating Mr. Regula for gastrointestinal problems. The Committee did not find Dr. Shapero's statements persuasive since he is not qualified to, and pointed out that he would not, opine on Mr. Regula's orthopedic and psychological difficulties.

With regard to Dr. Smith, the Committee noted Dr. O'Brien's criticisms of her opinion, and also reviewed Dr. Smith's comments about Dr. O'Brien's opinion. The Committee noted that Dr. Smith was opining on Mr.

Regula's orthopedic difficulties when she is not an orthopedic medical doctor. With regard to Mr. Regula's psychiatric care, the Committee found it difficult to believe that Mr. Regula will not consider prescription medicine therapy and also found it difficult to believe that Dr. Smith would state that he is totally disabled and continue to treat him without the use of medication. As Dr. O'Brien pointed out, a large amount of time has elapsed since Mr. Regula first tried prescription medicine therapy. Since that time, many new medicines have been developed that may not have the same side effects. To the Committee, Mr. Regula's refusal to consider prescription drug treatment gives the impression that he does not want to improve or that he is not truly disabled.

The Committee also considered the opinion of Dr. Cummings, but the Committee also noted that except for Dr. Cummings report, there is no current orthopedic or other medical information in the file that addresses the hand injury or back and neck pain and difficulties, which were the original bases for Mr. Regula's disability claim. The last information of this type was dated approximately 1990 or 1991. The Committee noted that this had been pointed out to you prior to the meeting.

After reviewing all of this information, the Committee determined that Mr. Regula is not totally disabled within the meaning of the Plan. The Committee was persuaded by the reports of the IME physicians, the lack of current medical information regarding Mr. Regula's hand and back injury, and the fact that Mr. Regula claims to be totally disabled from a psychological standpoint, but yet he refuses to consider any medication to treat his illness.

Finally, the Committee considered your arguments about their reliance on the treating physician's opinions. First, we disagree that the current ERISA case law

requires the Plan to give deference to the treating physician over that of other physicians. While the Committee agrees that in many cases the treating physician may know the most about an employee's condition, the Committee believes that there are many times when an independent or objective evaluation can be more valuable and insightful. Second, even if your position was correct, there was ample evidence in the file to suggest that the opinions of the treating physicians should be discounted. Primarily, the strong evidence that Mr. Regula is malingering would permit the Committee to place more emphasis on the opinion of the IME over that of the treating psychologist. Additionally, the Committee felt that there was no current opinion from a medical doctor regarding Mr. Regula's hand and back. As described above, Dr. Shapero could not and would not speak on these issues. Due to this, the Committee relied on the current medical opinion from the IME, Dr. Kumar.

Sincerely,

/s/ MONTY HILL

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 01-15450
Non-Argument Calendar
D.C. Docket No. 00-00577-CV-CAM-1

VICKIE C. TURNER,

Plaintiff-Appellant.

—versus—

DELTA FAMILY-CARE DISABILITY
AND SURVIVORSHIP PLAN,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Georgia

(April 9, 2002)

Before TJOFLAT and BIRCH, Circuit Judges,
and SHAPIRO*, District Judge.

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* Hon. Norma L. Shapiro, U.S. District Judge for the Eastern District of Pennsylvania, sitting by designation.

PER CURIAM:

Appellant Turner filed this action in state court to recover long term disability benefits from Appellee, Delta Family-Care Disability and Survivorship Plan (the "Plan"). The Plan, a non-contributory ERISA plan sponsored, funded and administered by Turner's former employer, Delta Air Lines, removed the action to federal court. On cross-motions for summary judgment filed in the District Court, the Plan's motion for summary judgment was granted. Turner timely appealed.

STATEMENT OF FACTS

The Plan is an ERISA non-contributory employee welfare benefit plan as defined in 29 U.S.C. § 1002(1). It provides short and long term disability benefits, as well as other benefits, to non-pilot Delta employees. The Administrative Committee of Delta Air Lines, Inc. is the Plan Administrator and the Named Fiduciary (as those terms are defined in ERISA).

Section 4.03 of the Plan sets forth the eligibility criteria for Long Term Disability Benefits and states, in relevant part:

> The Employee shall be eligible for Long Term Disability provided [s]he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent [her] from engaging in any occupation whatsoever for compensation or profit, including part-time work, but not including work performed in connection with a rehabilitation program approved by the Administrative Committee.

Section 12.01 of the Plan provides that the Administrative Committee, the Named Fiduciary of the Plan for purposes of operation and administration, has the exclusive power to interpret the Plan:

> The operation and administration of the Plan . . . the exclusive power to interpret it, and the responsibility for carrying out its provisions are vested in the Administrative Committee of at least three members, which Committee shall be the Administrator of the Plan. . . . The Administrative Committee shall establish rules for administration of the Plan and transaction of its business. The Administrative Committee shall be the named fiduciary of the Plan for purposes of operation and administration of the Plan. . . .

The powers and duties of the Administrative Committee are further defined in Section 12.02:

> In addition to powers and duties otherwise stated in this Plan, the Administrative Committee shall have such duties and powers as may be necessary to discharge its responsibilities under the Plan, including, but not limited to, the following:
>
> > (a) To establish and enforce such rules, regulations and procedures as it shall deem necessary and proper for the efficient operation and administration of the Plan;
> >
> > (b) The discretionary authority to interpret the Plan, and decide all questions of eligibility of any Eligible Family Member to participate in the Plan or to receive benefits under it, its interpretation and decisions to be final and conclusive;

> (c) To determine the amount, manner, and time of payment of benefits which shall be payable to any Employee or Dependent, in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits shall be paid;
>
> * * *
>
> (g) To decide all questions concerning the Plan;
>
> * * *
>
> (i) To delegate all its power and duties as set forth in Section 11.04.
>
> **The Administrative Committee shall have the broadest discretionary authority permitted under law in the exercise of all of its functions including, but not limited to, deciding questions of eligibility, interpretation, and the right to benefits hereunder but shall act in an impartial and nondiscriminatory manner with respect thereto.** (emphasis added.)

According to Section 12.03, the Administrative Committee's decisions "as to interpretation and application of the Plan shall be final."

While working as a flight attendant in August, 1996, Turner was injured and filed a claim for short term disability benefits, as well as a claim for workers' compensation. Short term disability benefits were payable as long as plaintiff could not return to her previous employment. Ms. Turner received short term disability benefits under the Plan from August 14, 1996 until February 11, 1997. Ms. Turner received workers' compensation benefits at the same time.

On February 8, 1997, Ms. Turner filed an application for long term disability benefits. Long term disability benefits were payable under the Plan so long as Ms. Turner was unable to engage in any occupation for compensation or profit, including part-time work. Ms. Turner's application for long term disability benefits was approved on April 3, 1997, effective February 12, 1997. Ms. Turner continued to receive long term disability benefits for two years (28 months) until June 7, 1999, when her benefits were stopped. The total period Ms. Turner received short and long term disability benefits was 34 months.

Turner appealed the termination of her long term disability benefits in June, 1999. Delta sent a clerical job description to one of Turner's treating physicians who responded that she could do clerical work with certain restrictions: changing positions as needed; no repetitive lifting, twisting or bending; and lifting limited to 10 pounds. This evaluation followed the doctor's earlier and subsequent recommendation of an intradiscal procedure to allow Turner to return to employment.

Turner's administrative appeal was denied as of June 7, 1999, "Based on the convincing opinions of her own physician, Dr. Chambers, and of the IME physician, Dr. Dopson, that you were able to perform some type of work as of your denial date and the lack of evidence to the contrary, the committee was not persuaded that you were eligible for additional long-term disability benefits."

STANDARD OF REVIEW

A District Court grant of summary judgment is subject to *de novo* review. The Court of Appeals must determine whether, based on the evidence of record, it agrees with

the District Court that the Plan had some reasonable basis for its decision to discontinue claimant's long-term disability benefits so that the Plan's decision was not arbitrary or capricious. *Canadyne-Georgia Corp. v. Continental Ins. Co.*, 999 F.2d 1547, 1554 (11th Cir. 1993); *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1449-1452 (1997).

Ms. Turner contends the Plan's decision is subject to a modified arbitrary or capricious standard of review because Delta is making decisions over funds contributed by Delta and, as Plan funds are disbursed, Delta is obligated to replenish them. Even though the monies are paid from a trust funded by Delta through irrevocable periodic contributions, the Plan has finite resources to pay benefits and decisions on disbursements are made by a committee made up of Delta employees. Delta maintains control over benefits because its employees are on the Administrative Committee making decisions on benefits.

This court decided in *Paramore v. Delta Air Lines*, 129 F.3d 1446 (11th Cir. 1997), that the arbitrary or capricious standard of review applies to this Plan's decisions because of the broad discretion delegated to the Plan's Administrator in the Plan document. This court has also previously decided, in *Buckley v. Metropolitan Life Ins. Co.*, 115 F.3d 936 (11th Cir. 1997) (per curiam) that the funding structure utilized by this Plan eradicates any alleged conflict of interest so that the arbitrary or capricious standard of review applies.

In the more recent decision of *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1138 (9th Cir. 2001), the members of the Administrative Committee were appointed by the Delta Board of Directors; although the Benefit Fund was organized as a trust, it was funded exclusively by Delta companies based on

actuarial data and Delta effectively acted as both administrator and funding source for the Plan. The 9th Circuit Court of Appeals held in *Regula*, "[u]nder such circumstances, Plan benefits decisions are subject to a less deferential standard of review." But Turner's argument that this less deferential standard should apply here is unavailing because of the decisions of this Court to the contrary.

Turner also argues that the District Court failed to give deference to the opinions of her treating doctors. She again relies on *Regula*. The 9th Circuit Court of Appeals held not only that Plan benefit decisions are subject to a less deferential standard of review but also that due deference should be given to opinions of the treating physician who has a greater opportunity to know and observe the patient as an individual.

The *Regula* decision is contrary to the law of this Circuit and cannot govern this appeal. But even if it did, it would not benefit Turner as her treating physician on at least one occasion stated Turner was capable of performing the job description of a clerk, with minor restrictions. The Plan was entitled to rely on that opinion in July, 1999, even if in June, 1999, her doctor had been of the opinion she could not return to her previous occupation of flight attendant. The Plan criterion for long-term disability was inability to work at any occupation.

The Plan was also entitled to rely on the opinion of the independent medical examiner to whom Turner was referred in light of the surveillance report it requested. On January 20, 1999, Turner was observed by investigators for the Plan. Turner was walking in a fluid manner without visible restrictions or medical devices at a bank prior to a doctor's appointment. Turner was then observed walking from the doctor's office with a sig-

nificant limp and using a cane. Upon arrival at her home, Turner was observed leaning without assistance into the back seat of her car to remove her cane, and entering her residence "without limping as significantly as she did at the medical office, and she did not use her cane."

On February 3, 1999, Turner was again observed by investigators for the Plan. The investigator's report states Turner was observed driving alone to a nearby mall. She was inside the mall for approximately two hours, during which time she was observed walking, shopping, and descending stairs without the use of a cane. The investigator further observed that "[a]t times, she walked with an emphatic limp, and at other times her stride appeared fluid."

All medical reports and other evidence was considered; all procedures required by the Plan were followed. Whether or not Turner could return to regular duty as a flight attendant, the determination that she was not totally disabled from performing any work in June, 1999, was far from arbitrary and capricious. It is irrelevant that the court or anyone else might reach a different conclusion. Upon consideration of the briefs and record, there was no reversible error. The decision of the District Court is AFFIRMED.